

## **Bundle Audit Committee 5 November 2024**

- 1 09:30 - PRELIMINARY MATTERS
  - 1.1 09:30 - AC24/142 Welcome and Apologies - Verbal (Chair)
  - 1.2 09:32 - AC24/143 Declarations of Interest - Verbal (Chair)
  - 1.3 09:34 - AC24/144 Unconfirmed Minutes of Meetings held on 12.09.24 - Attached (Chair)  
AC24.144 Minutes from Audit Committee 12.09.24 V0.05 Unconfirmed (Public) New Format
  - 1.4 09:37 - AC24/145 Matters Arising and Action Log - Attached (Chair)  
AC24.145.1 Summary Action Log Audit Committee (Updated 29.10.24) Public  
AC24.145.2 Coversheet CIHC concerns update  
AC24.145.3 Complaints Powerpoint 29.09.24
- 2 09:47 - GOVERNANCE
  - 2.1 09:47 - AC24/146 Update Report on Internal and External Audit Recommendations - Paper (Director of Corporate Governance)  
AC24.146.1 Audit tracking report 05.11.2024 v1.00  
AC24.146.2 App 1 Closure summary table v1.00  
AC24.146.3 App 2 All unsatisfactory open v1.00  
AC24.146.4 App 3 All open limited v1.00  
AC24.146.5 App 4 - IA Pre-2022 Closed Implemented v1.00  
AC24.146.6 App 5 - Pre-2022 - IA Other v1.00  
AC24.146.7 App 6 - 2022-23 IA Closed Implemented v1.00  
AC24.146.8 App 7 - 2022-23 IA Other v1.00
  - 2.2 10:07 - AC24/147 Update on Outstanding Audit Recommendations - Presentation (Interim Executive Director of Finance)  
*To follow*
  - 2.3 10:22 - AC24/148 Welsh Health Circulars and Ministerial Directions - Paper (Associate Director of Governance / Head of Covid-19 and Thirlwall Inquiry)  
AC24.148.1 WHCs and MDs report v1.00  
AC24.148.2 App 1 - WHC Library v1.00  
AC24.148.3 App 2 - MD Library v1.00
  - 2.4 10:37 - AC24/149 Declarations of Interests / Gifts & Hospitality - Paper (Head of Corporate Affairs)  
AC24.149 Audit Committee - Declarations of Interests Gifts and Hospitality
  - 2.5 10:47 - AC24/150 Minor Changes to Scheme of Delegation - Paper (Head of Corporate Affairs)  
AC24.150 Audit Committee - SORD Update
  - 2.6 10:57 - AC24/151 Response to Freedom of Information Request - Paper (Director of Corporate Governance / Associate Director of Governance)  
AC24.151 FOI Paper 5 November
- 3 11:12 - FINANCIAL FOCUS
  - 3.1 11:12 - AC24/152 Conformance Report: Q2 2024/25 - Paper (Interim Executive Director of Finance)  
AC24.152 Audit Committee - Conformance Report - Quarter 2 2024
  - 3.2 11:27 - AC24/153 Penalties from the Welsh Risk Pool - Paper (Director of Corporate Governance / Deputy Director for Legal Services)  
AC24.153 November 2024 - ET and AC -WRP Penalties (MJ paper on WRP)
- 4 11:42 - INTERNAL AUDIT

- 4.1 11:42 - AC24/154 Internal Audit Progress Report - Paper (Head of Internal Audit)
  - AC24.154.1 IA progress report Cover Sheet Nov 2024
  - AC24.154.2 BCUHB Audit Committee progress report November 2024
  - AC24.154.3 BCU SSU 2324 02 Final Audit Report Orthopaedics Project Llandudno Hospital
  - AC24.154.4 BCU 2425 16 Final Internal Audit Report Fire Safety
  - AC24.154.5 Internal Audit Report Template v1 Oct 2024
- 4.2 11:57 - AC24/155 Internal Audit Plan (Oct 24 to March 25) - Paper (Head of Internal Audit)
  - AC24.155 Draft BCUHB Internal Audit plan 2024-25 Oct24toMar25 v2 (003)
- 5 12:12 - EXTERNAL AUDIT
- 5.1 12:12 - AC24/156 External Audit Progress Report - Paper (Audit Manager, Audit Wales)
  - AC24.156.1 BCU Audit Committee Update 05112024
  - AC24.156.2 BCUHB Review of Cost Savings Arrangements
- 6 12:32 - COUNTER FRAUD
- 6.1 12:32 - AC24/157 Local Counter Fraud Service Progress Report (Q2) - Paper (Interim Executive Director of Finance)
  - AC24.157 BCUHB Counter Fraud Progress Report - Quarter 2 - 2024-25 (Public)
- 7 12:47 - FOR INFORMATION
- 7.1 12:47 - AC24/158 Summary of Business to be Reported from Private - Paper (Head of Corporate Affairs)
  - AC24.158 Audit Private session items reported in public
- 7.2 12:49 - AC24/159 Forward Workplan - Paper (Project Support Manager (Corporate Governance)
  - AC24.159 Workplan for Audit Committee (Live Version as at 24.10.24)
- 8 12:51 - CLOSING BUSINESS
- 8.1 12:51 - AC24/160 Agree Items for Referral to Board / Other Committees - Verbal (Chair)
- 8.2 12:56 - AC24/161 Review of Meeting Effectiveness - Verbal (Chair)
- 8.3 13:01 - AC24/162 Date of Next Meeting - 16.01.25
- 8.4 13:01 - Resolution to Exclude the Press and Public
 

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



**Betsi Cadwaladr University Health Board (BCUHB)**  
**UNCONFIRMED Minutes of the Audit Committee**  
**held in Public on 12 September 2024**  
**in the Boardroom, Carlton Court, St Asaph and via Teams**

| Committee Members Present |                                                                   |
|---------------------------|-------------------------------------------------------------------|
| Name                      | Title                                                             |
| Karen Balmer              | Independent Member (Chair of Audit Committee)                     |
| Urtha Felda               | Independent Member                                                |
| Dyfed Jones               | Independent Member ( <i>part meeting – via Teams</i> )            |
| Rhian Watcyn Jones        | Independent Member ( <i>via Teams</i> )                           |
| In Attendance             |                                                                   |
| Russell Caldicott         | Interim Executive Director of Finance                             |
| Pam Wenger                | Director of Corporate Governance                                  |
| Carol Shillabeer          | Chief Executive                                                   |
| Andrew Doughton           | Audit Manager, Audit Wales                                        |
| Michelle Phoenix          | Performance Audit Lead, Audit Wales                               |
| Dave Harries              | Head of Internal Audit                                            |
| Nicola Jones              | Deputy Head of Internal Audit ( <i>part meeting – via Teams</i> ) |
| Nesta Collingridge        | Head of Risk Management ( <i>part meeting</i> )                   |
| Jason Brannan             | Deputy Director of People & OD ( <i>part meeting</i> )            |
| Gareth Evans              | Senior Organisational Development Manager ( <i>part meeting</i> ) |
| Committee Support         |                                                                   |
| Philippa Peake Jones      | Head of Corporate Affairs                                         |
| Laura Jones               | Project Support Manager (Corporate Governance)                    |

## PRELIMINARY MATTERS

### AC24/116 Welcome and Apologies

The Chair of the Committee welcomed everyone to the meeting and apologies were received for Dyfed Edwards, Nick Lyons, Sjeff Molmans and Fflur Jones.

On behalf of the Committee the Chair extended condolences to the Internal Audit team for the sad loss of their colleague Huw Jones and formally acknowledged Huw's contribution of audit work to the Health Board.

### AC24/117 Declarations of Interest

No declarations of interest were raised at the meeting.

### AC24/118 Unconfirmed Minutes of Meetings held 09.07.24 and 18.07.24

There was discussion around the format of minutes and clarity on what is being reported and recorded. The Director of Corporate Governance stated that there had been a change in support to the Committee, the aim is to address this at the Chair's Advisory Group and gain agreement that going forward minutes will highlight key matters of discussion, actions and decisions.



#### Action:

- AC24/118.1 The Director of Corporate Governance agreed to meet with Rhian Watcyn-Jones with regards to her experience with minutes writing.

It was resolved that the Committee:

- Agreed that the minutes of the meetings held on 09.07.24 and 18.07.24 were a true and accurate record subject to the following amendment: - 18.07.24 under item AC24.103.2 where this should read 'he' rather than 'she'.

### AC24/119 Matters Arising and Action Log

#### Operating Model

- Rhian Watcyn-Jones raised a query in relation to point **AC24.101.15** in the minutes from 18.07.24 and requested clarity on the date and mechanism in relation to the Operating Model and the engagement process with Board Members. The Chief Executive confirmed that the People & Culture Committee are leading on the Operating Model stating that the programme has now been established, the end of the discovery phase is being finalised and engagement with Board Members will take place once this has been completed. It was agreed to add this action to the action log.

#### Trusted Assessor

- Rhian Watcyn-Jones raised a query in relation to action **AC24.101.13** which refers to the Trusted Assessor, the Chief Executive confirmed that this will be covered in the Urgent and Emergency Care paper going to the Board in September and is part of the work taking place with Local Government.

#### Actions:

- AC24/119.1 Director of Corporate Governance / Head of Corporate Affairs to add action **AC24.101.15** to the action log.
- AC24/119.2 As requested by the Chair, actions **AC24.43.6** and **AC24.45.9** to be added to the action log from a previous version.

The Committee reviewed the action log and agreed to close the following actions: **AC24.20.1, AC24.39.8, AC24.45.12, AC24.46.2, AC24.46.3, AC24.46.6, AC24.61.2.4, AC24.80.7, AC24.86.3, AC24.90.2, AC24.91.1, AC24.94.10, AC24.95.7, AC24.98.3 & AC24.102.7.**

### GOVERNANCE

#### AC24/120 Board Assurance Framework (BAF) and Risk Governance Arrangements

Members received the report and noted the progress in relation to risk management. In presenting the report, the Head of Risk Management highlighted:

- The five strategic risks included in the paper stating that these were approved by the Board in July 2024.
- A paper will be considered by the Executive Team in relation to the alignment of the Board Assurance Framework as set out in the Annual Delivery Plan.
- Risk governance arrangements are progressing well in relation to the Internal Audit recommendations following the recent Internal Audit Report.



- The Risk Scrutiny Group, has now been established and will allow oversight of the corporate risk register prior to scrutiny by the Executive Team.
- Oversight of risk governance arrangements for each directorate and division has been progressing and the team have set up a cycle of audits based on risk maturity and work is progressing in relation to improvement plans.
- In June 24 the assessments by the Corporate Risk Team noted an improvement in overdue risks from 53% to 35%, work has taken place in relation to communication, engagement and training and progress is being made.

In discussing the report, the Committee:

- Referred to the scoring mechanism related to the risk audit results agreeing that this would be shared with the Committee to allow an understanding of the scoring matrix.
- Confirmed that staff are engaging well with risk, the team are currently delivering level 3 strategic training and requests have been made from senior managers and clinical leads for additional sessions to gain a greater understanding of risk.
- There was discussion around the high-level risks and potentially breaking those down to ensure the teams deliver the strategic objectives and provide sufficient assurance to the Board.
- Commented on whether the training will continue on an annual basis and gained confirmation that this is included in the training plan which has been approved.
- Reflected on the work completed to date and stated the need to gain a greater understanding of the risks that may prevent the organisation delivering its strategic objectives and having a clear view in terms of the action being taken to avoid those risks.
- Highlighted some issues in relation to terminology, assurance and areas with a basic risk maturity level but also provided positive feedback on the progress that has been made to date.
- Concluded that this area of work is progressing well and by the start of the next financial year the organisation should have a stronger approach to both risk and the board assurance framework. It was confirmed that the team will continue to provide updates to the Committee for assurance.

*Dyfed Jones joined the meeting*

#### **Action:**

- AC24/120.1 Director of Corporate Governance / Head of Risk Management to share the point scoring matrix with the Committee and possibly some examples of completed audits and improvement plans via email.

It was resolved that the Committee:

- **NOTED** the progress of the Board Assurance Framework; and
- **RECEIVED** assurance on the governance arrangements as part of the Committees responsibility.

*Jason Brannan and Gareth Evans joined the meeting*

#### **AC24/121 Review Speaking Up Safely / Whistle Blowing Arrangements**

Members received the report and noted the progress in relation to Speaking Up Safely. In presenting the report, the Deputy Director of People highlighted:

- The team have played an important part in developing the national approach;
- During October, Welsh Government released the Speaking Up Safely framework;
- Speaking Up Safely is a key piece of work that links to organisational culture and it was noted that funding within the directorate has been reallocated to support this;
- Plans were in place to appoint a lead guardian to oversee the guardian cohorts and lead on the provision of the service; and
- The team are currently developing an action plan and are keen to have discussions around nominating an organisational champion at Board level.

In discussing the report, the Committee:

- Referred to the data highlighting concerns around leadership and management and the need for further work in relation to quality, diversity and inclusion;
- Discussed the activity data relating to the Work in Confidence and Freedom to Speak Up as to how this can be captured as a collective, suggesting this information could be consolidated going forward to help focus on the areas of concern;
- Commented on the role of the guardians recognising that as the values and behaviours work continues there may be further incidences of people using the Speaking Up Safely process;
- Stated the need to raise awareness of the process and encourage staff to come forward;
- Agreed the need to capture the outcomes of the process to allow the team to gain a measurement of the satisfaction for users;
- Discussed the use of policies in relation to the number of concerns being raised and agreed that comparing the figures against other Health Board would be useful;
- Suggested the need for distinction between whistle blowing and counter fraud highlighting issues in relation to identification of individuals and the need to provide support in this area;
- Commented on the origin of the board effectiveness review and the insufficient arrangements at that time for raising concerns internally suggesting this needs to be addressed along with the learning from the previous process;
- Noted the observations shared stating that the aim is to implement an effective Speaking Up Safely process, there is work to be done around communication and once the lead guardian is in post, they will be able to promote the service more widely across the organisation;
- Confirmed that this item was being discussed at Audit Committee to provide assurance that there are effective policies and processes in place; and
- Agreed that a future update would consider the compliance against the policy/protocol in the context of raising concerns and Whistleblowing arrangements.

#### **Actions:**

- AC24/121.1 Deputy Director of People & OD to share benchmarking information from other Health Boards in relation to the number of concerns being raised.
- AC24/121.2 Future update to consider the compliance against the policy / protocol and particularly in the context of raising concerns and Whistleblowing arrangements.

It was resolved that the Committee:

- **NOTED** the continued development of the Speaking Up Safely approach in BCUHB.

*Jason Brannan and Gareth Evans left the meeting.*

## AC24/122 Internal and External Audit Tracker Report

Members received the report and noted the progress in relation to the audit tracker. In presenting the report, the Director of Corporate Governance highlighted:

- Work is being developed to provide effective reporting arrangements and move forward in terms of outstanding recommendations and actions;
- Discussions have taken place with Internal Audit to ensure all actions, including historic actions have been captured and the team have developed a system where recommendations are being marked as closed subject to confirmation by Audit; these will remain on the tracker until sign off agreed by Audit and approved by the Committee;
- In reviewing progress against Internal Audit recommendations, the team will reference the progress in the Internal Audit report to provide a line of assurance;
- Confirmation that the report includes updates against recommendations that were unsatisfactory or no assurance and going forward a summary will be included to provide oversight; and
- A presentation template has been included in the papers with the aim of inviting Executive Directors to future meetings to provide an update on their recommendations and assurance in terms of progress.

In discussing the report, the Committee:

- Considered the unsatisfactory assurance recommendation on the Operating Model and it was confirmed that the programme has been established and by the end of quarter 2 the aim is to share the output of the work.
- Confirmed that the design work relating to the Operating Model has now commenced and discussions will take place with Board Members shortly.
- Referred to the presentation provided by Dave Thomas at the Chairs of the Audit Committee across Wales meeting relating to Audit tracking and agreed to share this with members.
- Discussed the recommendations that had been returned to Internal Audit for review and the Head of Internal Audit apologised for the delay confirming this would be completed ahead of the next meeting in November 24.

### Action:

- The Director of Corporate Governance to share the Audit tracking presentation from the Chairs of the Audit Committee across Wales with members.

It was resolved that the Committee:

- **NOTED** the current position with regards to open recommendations, those proposed for closure, and 'no', 'unsatisfactory' and 'limited' assurance recommendations;
- **APPROVED** the agreement made between the Director of Corporate Governance and Internal Audit relating to those recommendations listed as 'Closed – Verified' on the TeamMate update; and
- **AGREED** to nominate an Executive Director to provide an update on their open 'no/limited/unsatisfactory' assurance recommendations at the November meeting.



## AC24/123 Director of Corporate Governance Update on Open "Limited" Audit Recommendations

Members received the report and noted the progress in relation to risk management. In presenting the report, the Director of Corporate Governance highlighted:

- The presentation template had been discussed at the Executive Team for agreement on the approach in advance of Audit Committee; and
- Made reference to the progress against the limited assurance reports in terms of risk management, standards of business conduct and the progress to date.

In discussing the report, the Committee:

- Specified the need to be more detailed in terms of timescales and the progress being made in relation to the civica system and the standards of business conduct policy.
- Stated that the template provides consistency around the level of information and assurance being reported and agreed to include additional information;
- Discussed which Executive Director should be invited to present at the next meeting;
- Stated that this process is a welcome addition and would allow the Committee to hold people to account.
- Agreed that this process would assist the Directorate and Service Performance Reviews and highlight areas of concern where additional support is required.
- Referred to the current challenges in relation areas of work such as the systems of internal control and the need to provide insight into the factors that are delaying progress being made.
- Queried recommendation 1274 which appeared to have been removed from the tracker.

### Actions:

- AC24/123.1 The Director of Corporate Governance to add additional column in the chart highlighting the recommendation number to be able to cross reference the information in the presentation with the report and also to provide additional narrative in relation to the barriers to implementation section as necessary.
- AC24/123.2 The Interim Executive Director of Finance agreed to be the Executive Director presenting at the next meeting.
- AC24/123.3 The Director of Corporate Governance to review the audit tracker and confirm the position in relation to recommendation 1274.

It was resolved that the Committee:

- **NOTED** the progress against the limited assurance recommendations for the Director of Corporate Governance; and
- **AGREED** to use this format subject to minor amendments going forward

*Nesta Collingridge and Nicola Jones left the meeting*

## AC24/124 Update on Health Board Policies and Written Control Documents (WCDs)

Members received the report and noted the progress in relation to risk management. In presenting the report, the Director of Corporate Governance highlighted:



- Work is taking place across the organisation to reduce the number of policies and the Executive Team have established a Policy Oversight Group to focus on making progress in this area;
- The report is presented to provide assurance in terms of the approach and will come back on a bi-annual basis to allow the Committee to have oversight of the progress being made;
- An amendment to the policy on policies document was also highlighted.

In discussing the report, the Committee:

- Suggested ensuring policies are accessible and being used as required and also requested an updated position in terms of the figures included in the report.
- Commented on the high volume of policies within the organisation,
- Highlighted an element of the structured assessment which relates to the Health Board being aware of the policies required to safeguard the organisation and those areas that may provide greater risk.
- Emphasised the difference between policies and procedures and what level of scrutiny is required. The Director of Corporate Governance invited the Head of Internal Audit and Deputy Head of Internal Audit to join the Policy Oversight Group to provide some guidance.

#### **Actions:**

- AC24/124.1 The Director of Corporate Governance agreed to provide clarity outside of the meeting in terms of the most up to date position on the summary of overdue WCDs.
- AC24/124.2 A summary to be provided at the next meeting as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.
- AC24/124.3 It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future.
- AC24/124.4 Head of Internal Audit and Deputy Head of Internal Audit to join the Policy Oversight Group to provide some guidance.

It was resolved that the Committee:

- **NOTED** the current status of all out-of-date policies and WCDs;
- **NOTED** the policies and WCDs that will become overdue per quarter in 2024/2024; and
- **APPROVED** the change in the approval process for all Health Board-wide clinical or non-clinical policies, including those with an element of medicine management.

#### **AC24/125 Update Report on Structured Assessments**

**AC24/125.1** Members received the report and noted the progress in relation to historic structured assessments undertaken by Audit Wales. In presenting the report, the Director of Corporate Governance highlighted:

- Work that has taken place to provide an update position in relation to historic structured assessment recommendations.

In discussing the report, the Committee:



- Supported the closure of the historic recommendation 7 relating to 2019 following confirmation from Audit Wales;
- Noted the progress updates against outstanding recommendations from 2022 and 2023.

#### Action:

- AC24/125.1 It was agreed that a deadline date and a target date for completion against the historic structured assessment recommendations would be included along with updates in the audit tracking report in future.

It was resolved that the Committee:

- **NOTED and AGREED** the recommendations which have been confirmed as completed, closed, or superseded; and
- **NOTED** the progress and position in respect of those recommendations that currently remain open.

### AC24/126 Audit Committee Development Plan

**AC24/126.1** Members received the report and the contents of the proposed development plan. In presenting the report, the Director of Corporate Governance highlighted:

- The proposal to hold one-hour sessions in between Committees as an educational development programme for members. The sessions would cover areas such as Counter Fraud, Internal and External Audit with the aim of upskilling members and allowing the Committee to work more effectively going forward.

In discussing the report, the Committee:

- Considered the content of the sessions and arranging relevant sessions in a timely manner such as holding a session on the accounts during the relevant period.
- Noted that some subjects proposed should be part of induction e.g. The role of Internal and External audit rather than within the Committee development plan.
- Suggested including topics related to changes in legislation and areas of accountability within the system and gaining an understanding of where items sit in relation to other areas within the Health Board such as the Speaking Up Safely item and where that sits within the wider remit to provide members with some additional context.
- Reflected on the role of the Committee in terms of its relationship with other Committees for example, in the past a Joint Committee has been held with Audit and QSE to review clinical audit outcomes.

#### Action:

- AC24/126.1 It was agreed to schedule the development sessions and to review the content of the programme interlinking this with the cycle of business.

It was resolved that the Committee:

- **NOTED and AGREED** the proposal to hold bi-monthly development sessions; and
- **AGREE** the proposed topics (under review) for the sessions going forward

### INTERNAL AUDIT

#### AC24/127 Internal Audit Progress Report



Members received the report and noted the progress in relation to Internal Audit. In presenting his report, the Head of Internal Audit highlighted:

- The team produced the report in line with the original date of the Committee due to be held on 03.09.24 therefore the cut-off date for the data was 12.08.24.
- Two reports have been issued as final with reasonable assurance in relation to the follow up of "Recruitment of substantive and interim executive and senior posts" and "Value Based Healthcare".
- The Fire Safety report is awaiting response and is based around operational compliance with statutory training which is an area of risk for the Health Board. Work is ongoing in relation to the Orthopaedic Surgical Hub; the team are awaiting a revised management response and this was noted as a limited assurance report particularly in relation to the governance arrangements.
- The other reports are in progress and are due to be released by the end of September 24.

In discussing the report, the Committee:

- Noted and approved the deferral of three audits to 2025/26 which had been included in the audit plan 2024/25.
- Noted the addition of; Consultant Job Planning to the 2024/25 audit plan.
- Referred to the Civil Contingencies Act, stating that this is a significant risk area for the Health Board as a Category One Responder that will require some additional assurance from the Executive on progress.
- Highlighted the Chief Executive's concern in this area noting that this has been included in the Annual delivery Plan as a priority.
- Noted that the topic of Emergency Preparedness, Resilience and Response has also been included on the agenda for the October meeting of the Planning, Population Health and Partnerships Committee and feedback will be provided to the Audit Committee.
- Agreed that a review on Consultant Job Planning would be added to the 2024/25 internal audit plan;
- Noted that the management response time had remained static but was moving towards target.
- Highlighted that the second six-month plan has been developed and proposed that this would be circulated to members before coming back to the Committee in November for formal presentation.

#### **Actions:**

- AC24/127.1 Head of Internal Audit to share the draft internal audit report in relation to the Orthopaedic Surgical Hub, Llandudno with the Chief Executive and the Director of Corporate Governance.
- AC24/127.2 Agreed that EPRR/Civil contingencies will go to the Planning, Population Health and Partnerships in October and feedback on the discussion will be provided back to the Audit Committee.
- AC24/127.3 The Head of Internal Audit to circulate the second six-month Audit Plan to members before coming back to the Committee in November 24 for formal presentation.
- AC24/127.4 To consider options for raising awareness and understanding of internal audit.

It was resolved that the Committee:

- **RECEIVED** the progress report; and
- **APPROVED** the changes to the plan for the People & OD Strategy, Civil Contingencies Act, Concerns and Complaints and Consultant Job Planning reviews

## EXTERNAL AUDIT

### AC24/128 External Audit Progress Report

Members received the report and noted the progress in relation to External Audit. In presenting the report, the Audit Manager and Performance Audit Lead for Audit Wales highlighted:

- The final accounts memorandum is due to be issued and engagement with Charitable Funds has commenced ahead of the audit due at the end of January 2025.
- The deep dive work on financial efficiencies has now been issued in draft and the background research work on the structured assessment has commenced.
- Reference was made to the consultation relating to fee scales in terms of daily charge and quantum of work and the uplift of around 2% and it was agreed that the document would be shared with the Committee.

In discussing the report, the Committee:

- Highlighted an error in the report where reference was made to the Trust rather than the Health Board;
- Noted the very tight deadline for the completion of the charitable funds audit and the need to submit the annual return to the charity commission by the 31<sup>st</sup> January, and
- Noted the update from the Chief Executive confirming the reset of Executive Director roles stating that Imran Devji is now the Interim Chief Operating Officer and Gareth Evans is now the Interim IHC Director (Centre)

#### Action:

- AC24/128.1 The Audit manager for Audit Wales to share the consultation on the Fee Scale for 2025-26 with the Committee.
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It was resolved that the Committee:

- **NOTED** the update from Audit Wales
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## FOR INFORMATION

### AC24/129 Audit Wales Community Pharmacy Data Matching Pilot Welsh Government Response

The Director of Corporate Governance confirmed that the report is for information and is part of a national piece of work that is ongoing. It was noted that the Chief Pharmacist's office and the Counter Fraud Team were reviewing their arrangements to minimise the risk of fraud and that this work would be brought to the Committee for assurance.

#### Action:

- AC24/129.1 It was agreed to add the item to the forward workplan for the January 25 meeting.

It was resolved that the Committee :





- **NOTED** the content of the Welsh Government's response to Audit Wales' community pharmacy data matching pilot.

#### **AC24/130 Summary of Business to be Reported from Private**

It was resolved that the Committee **NOTED** the report.

#### **AC24/131 Committee Cycle of Business and Forward Workplan**

The Director of Corporate Governance confirmed that the cycle of business has been mapped to HFMA NHS Audit Committee Handbook and the forward workplan will remain active.

#### **CLOSING BUSINESS**

#### **AC24/132 Agree Items for Referral to Board / Other Committees**

It was resolved that the Emergency Preparedness, Resilience and Response (EPRR) would be referred to the Planning, Population Health & Partnerships Committee.

#### **AC24/133 Review of Meeting Effectiveness**

In discussing the item, the Committee:

- Noted that the meeting had been effective with good focus on the appropriate areas.
- Requirement to close the loop on items that are referred to other Committees to ensure items are being taken forward.
- Noted by Internal Audit that progress is being made in relation to the board assurance framework and there is a need to strengthen how the Board and Committees take this forward to achieve the strategic goals of the organisation.
- Highlighted by External Audit that challenge had not been as constructive in the past however there is now a more transparent approach and the Committee should continue to embrace this to support improvement and provide confidence in the systems and arrangements in place.
- Noted that there had been a high level of challenge and support and issues are being discussed in a more confident and appropriate manner.
- Further work is required in terms of how people interact with the Committee and inviting the relevant people to join future meetings will help to shape this.
- Lastly it was noted that the sound was difficult via Teams.

#### **AC24/134 Date of Next Meeting**

Tuesday 5<sup>th</sup> November 2024, 9.30-13.30

#### **AC24/135 Resolution to Exclude the Press and Public**

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



## Audit Committee Action Log (Public)

Updated 29.10.24

| Open Actions |             |          |                                                                                                                                                                                                                                                                   |                                                                                      |                                                            |                                                                                                                                                                                                                                                                       |
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| Action No.   | Minute Ref. | Date     | Agreed Action                                                                                                                                                                                                                                                     | Lead                                                                                 | Timescale                                                  | Status                                                                                                                                                                                                                                                                |
| REMAIN OPEN  |             |          |                                                                                                                                                                                                                                                                   |                                                                                      |                                                            |                                                                                                                                                                                                                                                                       |
| 1            | AC24.43.6   | 15.03.24 | <b>Annual Timetable 23-24 Draft Final Accounts</b><br>To feedback to Committee in relation to the levels of exposure costs in terms of Welsh Risk Pool payments.                                                                                                  | Russell Caldicott                                                                    | May 2024<br><br>Revised timescale<br>Nov 2024              | <b>Remain Open</b><br><b>29.10.24</b> A paper on penalties from the Welsh Risk Pool has been include on the agenda for the November meeting.<br><b>03.05.24</b> Update to be provided at the meeting.                                                                 |
| 2            | AC24.57.7.5 | 07.05.24 | <b>Audit Tracker</b><br>The need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis was raised. It was agreed that the process for external audits needed to be different to the proposal in 2.1 of the report. | Pam Wenger<br>Russell Caldicott                                                      | July 2024<br>Nov 2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>02.09.24</b> Director of Corporate Governance to discuss with External Audit to agree closure process.<br><b>03.07.24</b> Process to be developed and agreed with External Audit following the end of year accounts process being concluded. |
| 3            | AC24.60.1.8 | 07.05.24 | <b>Internal Audit Progress Report</b><br>Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this       | Philippa Peake<br>Jones to inform the Quality, Safety and Experience Committee (QSE) | May 2024<br>Nov 2024<br><br>Revised timescale<br>Jan 2025  | <b>Remain Open</b><br><b>24.10.24</b> Action to remain open and to be taken forward with the new Director of Planning & Commissioning.<br><b>02.09.24</b> PPJ confirmed that this has been referred to QSE Committee                                                  |

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|   |              |          | decision and for the QSE committee to drive progress on recommendations from the May 23 report.                                                                                                                                                            |                                   |                                                            | however the issue has not yet been resolved therefore the action remains open.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 4 | AC24.60.1.10 | 07.05.24 | <b>Internal Audit Progress Report</b><br>Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Chairs Advisory Group as an emerging topic. | Karen Balmer<br>Pam Wenger        | July 2024<br><br>Revised timescale<br>Nov 2024             | <b>Remain Open</b><br><b>08.10.24</b> The recommendations included in the Lessons Learnt Audit Report have been shared with the Chair, this will be discussed at the Chairs Advisory Group in October and the Chair will provide a verbal update at the Audit Committee in November.<br><b>12.09.24</b> This will be discussed at the next Committee Chair's Meeting.<br><b>02.09.24</b> Update to be provided during the meeting.<br><b>18.07.24</b> To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair. |
| 5 | AC24.62.1.4  | 07.05.24 | <b>Local Counter Fraud</b><br>F03 <a href="#">BCUHB Counter Fraud Policy</a> is due for review – to be approved by August 2024. (Audit Committee Agenda in September)                                                                                      | Sjef Molmans<br>Russell Caldicott | Sept 2024<br>Nov 2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>25.10.24</b> With the recent appointment of the Head of Counter Fraud and the continued difficulties within the team owing to absence, the policy review has been deferred to the next Audit Committee for ratification with advice taken from national leads as to whether this offers a risk in relation to the recent changes in legislation.                                                                                                                                                                                 |



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|   |           |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                     | <p><b>12.09.24</b> RC to review the policy and check whether the legislation is due in September 24.</p> <p><b>05.09.24</b> The Counter Fraud Policy required further work and has been included on the forward workplan for the November meeting.</p> <p><b>26.06.24</b> Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July.</p> <p><b>20.05.24</b> Item now on CoB for September 2024.</p>                                                                             |
| 6 | AC24.94.9 | 18.07.24 | <p><b>Effective Governance – IHC Central Final Internal Audit Report</b></p> <p>The Chair of the Committee referred to the number of open complaints since April, and questioned the position at the end of June. The Director agreed to forward the detail to the Chair following the meeting, it was noted that overdue complaints had significantly reduced. It was also agreed to provide a future update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting.</p> | <p>IHC Director Central (<del>Libby Ryan Davies</del>)<br/>Di Platt / Gareth Evans</p> | <p>Sept 2024<br/>Nov 2024</p> <p>Revised timescale<br/>Jan 2025</p> | <p><b>Remain Open</b></p> <p><b>08.10.24</b> The Central IHC have provided a positional update of formal complaints and this has been included as an attachment to the action log (items AC24/145.2 &amp; AC24/145.3). The IHC will be invited to attend the meeting in Jan 25 to provide an update on the impact of the actions being taken.</p> <p><b>03.09.24</b> Since the July meeting there has been a change in the IHC Director Central role. The team are aware of the action and will provide a response ahead of the November meeting.</p> |
| 7 | AC24.99.8 | 18.07.24 | <p><b>Annual report from NHS Shared Services Partnership on Post</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Amanda Legge                                                                           | <p>Sept 2024<br/>Nov 2024</p>                                       | <p><b>Remain Open</b></p> <p><b>24.10.24</b> The prototype is still in</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |



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|   |             |          | <b>Payment Verification 2023/2024</b><br>The Committee Chair requested details on the availability of comparative trend analysis, including geographical data (in relation to East, Central and West IHC areas). The All Wales Post Payment Verification (PPV) Manager (NWSSP) agreed to provide this information.                                                                                                                                                                |              | Revised timescale<br>Jan 2025                              | development, the relevant data can be extracted and presented as an internal report, Committee to confirm whether they want this report to be presented at the next meeting in Jan 25 or for information to be shared outside of the meeting.<br><b>02.09.24</b> Amanda Legge confirmed that this information can be provide by locality area (e.g. Flintshire, Wrexham, Denbighshire, Conwy, Gwynedd & Anglesey). A prototype is being developed to include trend data and will be shared once available. |
| 8 | AC24.99.9   | 18.07.24 | <b>Annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024</b><br>The Director of Corporate Governance questioned if any particular themes had been raised upon the visits in terms of learning, and of the resolutions or progress and (where applicable) to counter fraud. The NWSSP Lead provided an overview of the current actions taken and it was agreed to include any anonymised common themes within future reports to the Committee. | Amanda Legge | Sept 2024<br>Nov 2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>24.10.24</b> As per update for action above<br><b>02.09.24</b> As per action above AC24.99.8 the information being collated will include any issues and common themes.                                                                                                                                                                                                                                                                                                            |
| 9 | AC24.101.13 | 18.07.24 | <b>Internal Audit Progress Report</b><br>An IM requested clarification on the                                                                                                                                                                                                                                                                                                                                                                                                     | Pam Wenger   | Sept 2024                                                  | <b>Remain Open</b><br><b>03.10.24</b> A paper on Urgent and                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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|    |            |          | role of the Trusted Assessor and the strengthening of this role within the overall process. The Director of Corporate Governance noted the request and agreed to arrange for the clarification to be provided to all Independent Members. |                                 | Revised timescale<br>Nov 2024                 | Emergency Care was presented to the Board in September which covered the role of the Trusted Assessor. Committee to confirm whether further action is required.<br><b>12.09.24</b> This will be covered in a paper going to the Board in September on Urgent and Emergency Care and is part of the work taking place with Local Government.<br><b>04.09.24</b> Briefing on the role of the Trusted Assessor to be commissioned.                                                                                           |
| 10 | AC24/121.1 | 12.09.24 | <b>Speak Up Safely</b> – Share benchmarking information from other Health Boards in relation to the number of concerns being raised.                                                                                                      | Jason Brannan<br>Gareth Evans   | Nov-2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>28.10.24</b> The Freedom to Speak Up Lead Guardian has begun liaising with colleagues from across the other Health Boards and will explore numbers of concerns as part of a benchmarking exercise, whilst also factoring in other considerations such as size of Health Board in relation to numbers of concerns received, and current impact factors that may also influence referral rates, e.g. impact of Special Measures and/or similar levels of external intervention into Health Boards. |
| 11 | AC24/121.2 | 12.09.24 | <b>Speak Up Safely</b> – Future update to consider the compliance against the                                                                                                                                                             | Internal Audit<br>Jason Brannan | Nov-2024                                      | <b>Remain Open</b><br><b>28.10.24</b> Speaking Up Safely as a                                                                                                                                                                                                                                                                                                                                                                                                                                                             |





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|    |            |          | policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.                                                                                                                                                          | Gareth Evans                | Revised timescale<br>Jan 2025                 | mechanism and route to raising concerns was included in the Raising Concerns policy and process when first launched in July 2021, and again reviewed when the Raising Concerns policy and process was updated. The SUS team will engage in further work to explore any specific additions or adaptations to current practice that may be needed in relation to Public Disclosure (Whistleblowing)<br><b>16.09.24</b> Internal Audit will consider Speak Up Safely as a key risk area for the 2025/26 internal audit planning cycle following presentation of the report by Officers and observations made by Committee Members. |
| 12 | AC24/124.2 | 12.09.24 | <b>Update on Health Board Policies and Written control Documents</b><br>A summary to be provided at the next meeting as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.             | Pam Wenger<br>Glesni Driver | Jan 2025                                      | <b>Remain Open</b><br><b>24.10.24</b> Work is in progress; this is being progressed via the Policy Oversight Group and the Executive Team. This will come to the Committee in January 25.                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 13 | AC24/124.3 | 12.09.24 | <b>Update on Health Board Policies and Written control Documents</b><br>It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future. | Pam Wenger<br>Glesni Driver | Nov 2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>24.10.24</b> The immediate focus is reviewing the work in terms of the governance and overdue policies. There is opportunity to review the current processes going forward but given the focus on dealing with                                                                                                                                                                                                                                                                                                                                                                                         |



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|                                     |            |          |                                                                                                                                                                                                                                                                           |                            |                                               | overdue policies this will be the immediate priority. This has been included on the forward workplan in terms of the long term review of the processes.                                                                                                                                                                                                            |
| 14                                  | AC24/127.2 | 12.09.24 | <b>Internal Audit Progress Report</b><br>EPRR/Civil contingencies will go to the PPHP Committee in October and feedback on the discussion will be provided back to the Audit Committee.                                                                                   | Pam Wenger                 | Nov 2024                                      | <b>Remain Open</b><br><b>03.10.24</b> A report on EPRR was considered at the PPHP Committee on 22.10.24 and it was agreed for the next meeting to receive an update in terms of the risks. The issue of the deferred audit was discussed and recognised that the Internal Audit Team had no option but to defer the audit.                                         |
| 15                                  | AC24/127.4 | 12.09.24 | <b>Internal Audit Progress Report</b><br>Consider options for raising awareness and understanding of internal audit.                                                                                                                                                      | Pam Wenger<br>Dave Harries | Nov 2024<br><br>Revised timescale<br>Jan 2025 | <b>Remain Open</b><br><b>03.10.24</b> PW to discuss options including developing video resource, an update will be provided in Jan 25.                                                                                                                                                                                                                             |
| <b>ACTIONS PROPOSED FOR CLOSURE</b> |            |          |                                                                                                                                                                                                                                                                           |                            |                                               |                                                                                                                                                                                                                                                                                                                                                                    |
| 1                                   | AC24.45.9  | 15.03.24 | <b>Internal Audit Reports</b><br>Regarding the Limited Assurance IA water safety report and responsibilities of areas, the Interim Executive Director of Finance agreed to gain further insight into the area responsibilities and risk sharing between Facilities staff. | Russell Caldicott          | May 2024<br><br>Revised timescale<br>Nov 2024 | <b>Action proposed for closure</b><br><b>25.10.24</b> Action to be closed, it is the responsibility of the Nursing teams to ensure the low flow areas (toilets with low use) are flushed and a record maintained.<br><b>03.05.24</b> The Estates provision of maintenance for areas was clarified as complete by Internal Audit, Nursing teams completion of water |



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|   |             |          |                                                                                                                                                                                                                                                                                                        |                                    |                                                | safety checks (flushing in low use areas) clear within action plan for rectification of key concerns.                                                                                                                                                                                                                                  |
| 2 | AC24.100.12 | 18.07.24 | <b>SFI Conformance Report</b><br>The Chair of the Committee requested clarification on the “phases” of breaches in the SFI Conformance Report on page 6 of 21, in relation to purchase order breaches. It was agreed for the Interim Director to follow up on the detail and report back to the Chair. | Andrea Hughes                      | Sept 2024<br><br>Revised timescale<br>Nov 2024 | <b>Action proposed for closure</b><br><b>24.10.24</b> Additional detail has been added into the report in Q2.<br><b>02.09.24</b> Clarity to be provided at the September meeting on the information required for the Conformance Report to be presented to the Committee in November 24.                                               |
| 3 | AC24.100.16 | 18.07.24 | <b>SFI Conformance Report</b><br>The Chair requested that a “movements” column be inserted into the SFI Conformance Report data in future reports to indicate progress or otherwise.                                                                                                                   | Andrea Hughes                      | Sept 2024<br><br>Revised timescale<br>Nov 2024 | <b>Action proposed for closure</b><br><b>24.10.24</b> Additional detail has been added into the report in Q2.<br><b>12.09.24</b> It was agreed that this action would remain open until the next meeting in November 24.<br><b>02.09.24</b> This will be incorporate into the Q2 report due to be received by the Committee in Nov 24. |
| 4 | AC24/118.1  | 12.09.24 | <b>Minutes</b> – Pam W to meet with Rhian W with regards to her experience with minute writing.                                                                                                                                                                                                        | Pam Wenger<br>Philippa Peake-Jones | Nov 2024                                       | <b>Action proposed for closure</b><br><b>03.10.24</b> PW and RWJ meeting 24.10.24 to discuss.                                                                                                                                                                                                                                          |
| 5 | AC24/119.1  | 12.09.24 | <b>Matters Arising and Action Log</b> – In relation to point AC24.101.15 in the minutes from the Audit Committee held 18.07.24, clarity was requested in relation to the Operating Model and the engagement process with Board Members in quarter 2.                                                   | Pam Wenger<br>Philippa Peake-Jones | Nov 2024                                       | <b>Action proposed for closure</b><br><b>Update provided in meeting</b><br><b>12.09.24</b> The People & Culture Committee are leading on this piece of work, the programme has now been established, the end of the discovery phase is being finalised                                                                                 |

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|    |            |          |                                                                                                                                                                                                                                                                                                                                   |                                  |          | and following this, engagement with Board Members will take place.                                                                                                                                                                                            |
| 6  | AC24/119.2 | 12.09.24 | Actions <b>AC24.43.6</b> and <b>AC24.45.9</b> to be added to the action log from a previous version.                                                                                                                                                                                                                              | Laura Jones                      | Nov 2024 | <b>Action proposed for closure 30.09.24</b> These actions have now been included on the action log.                                                                                                                                                           |
| 7  | AC24/120.1 | 12.09.24 | <b>BAF/Risk</b> – Share the point scoring matrix with the Committee and possibly some examples of completed audits and improvement plans via email.                                                                                                                                                                               | Pam Wenger<br>Nesta Collingridge | Nov 2024 | <b>Action proposed for closure 15.10.24</b> Risk Register Audit Template and Risk Register Review Cancer Services circulated via email 15.10.24                                                                                                               |
| 8  | AC24/122.1 | 12.09.24 | <b>Internal and External Audit Tracker Report</b><br>Share the Audit tracking presentation from the Chairs of the Audit Committee across Wales with members.                                                                                                                                                                      | Pam Wenger                       | Nov 2024 | <b>Action proposed for closure 07.10.24</b> The presentation was shared with members outside of the meeting.                                                                                                                                                  |
| 9  | AC24/123.1 | 12.09.24 | <b>Update on Open “Limited” Audit Recommendations</b><br>Add additional column in the chart highlighting the recommendation number to be able to cross reference the information in the presentation with the report and also to provide additional narrative in relation to the barriers to implementation section as necessary. | Pam Wenger<br>Glesni Driver      | Nov 2024 | <b>Action proposed for closure 16.09.24</b> The presentation template has been updated to include:<br>An additional column for the Internal Audit / Audit Wales recommendation reference number and information around the context required in the narrative. |
| 10 | AC24/123.2 | 12.09.24 | <b>Update on Open “Limited” Audit Recommendations</b><br>Russell Caldicott to be the Executive Director presenting at the next meeting.                                                                                                                                                                                           | Russell Caldicott                | Nov 2024 | <b>Action proposed for closure 01.10.24</b> This has been agreed and included on the agenda for the November meeting.                                                                                                                                         |



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

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|           | <b>AC24/123.3</b> | 12.09.24 | <b>Update on Open “Limited” Audit Recommendations</b><br>Check on where 1274 has moved to from the tracker.                                                                                                | Pam Wenger<br>Glesni Driver                | Nov 2024 | <b>Action proposed for closure</b><br><b>16.09.24</b> On checking the tracker in relation to recommendation 1274 it was noted there was an error as this was not included on the list of outstanding open recommendations, this has now been rectified.                             |
| <b>11</b> | <b>AC24/124.1</b> | 12.09.24 | <b>Update on Health Board Policies and Written control Documents</b><br>Clarify the most up to date position on Summary of overdue WCDs outside of the meeting.                                            | Pam Wenger<br>Glesni Driver                | Nov 2024 | <b>Action proposed for closure</b><br><b>01.10.24</b> The position as at 15.07.24 & 16.09.24 and supporting spreadsheets were shared with members outside of the meeting. The information showed a slight improvement from 361 to 340 overdue policies / written control documents. |
| <b>12</b> | <b>AC24/124.4</b> | 12.09.24 | <b>Update on Health Board Policies and Written control Documents</b><br>Head of Internal Audit and Deputy Head of Internal Audit to join the Policy Oversight Group to provide some guidance.              | Pam Wenger<br>Dave Harries<br>Nicola Jones | Nov 2024 | <b>Action proposed for closure</b><br><b>07.10.24</b> Dave Harries and Nicola Jones have been invited to attend the next meeting of the Group taking place on 17.10.24.                                                                                                             |
| <b>13</b> | <b>AC24/125.1</b> | 12.09.24 | <b>Structured Assessment</b><br>Add a deadline date and a target date for completion against historic structured assessment recommendations and to include updates in the audit tracking report in future. | Pam Wenger<br>Glesni Driver                | Nov 2024 | <b>Action proposed for closure</b><br><b>03.10.24</b> This will be added to the recommendation tracker in line with the Audit Wales standard template and will be noted as the “completion date”.                                                                                   |
| <b>14</b> | <b>AC24/126.1</b> | 12.09.24 | <b>Audit Committee Development Plan</b>                                                                                                                                                                    | Pam Wenger<br>Philippa Peake-              | Nov 2024 | <b>Action proposed for closure</b><br><b>03.10.24</b> The sessions have been                                                                                                                                                                                                        |

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|    |            |          | Schedule the development sessions and review the content of the programme interlinking this with the cycle of business.                                                                                          | Jones                              |              | agreed to take place on 05.12.24 and 20.02.24. The first session will focus on Counter Fraud.                                                                                                                                   |
| 15 | AC24/127.1 | 12.09.24 | <b>Internal Audit Progress Report</b><br>Dave Harries to share with Chief Executive and Director of Corporate Governance the draft internal audit report in relation to the Orthopedic Surgical Hub – Llandudno. | Dave Harries                       | Nov 2024     | <b>Action proposed for closure</b><br><b>08.10.24</b> A copy of the Final Audit Report was shared with Committee members on 08.10.24<br><b>13.09.24</b> Report shared with Chief Executive and Director of Corporate Governance |
| 16 | AC24/127.3 | 12.09.24 | <b>Internal Audit Progress Report</b><br>The second six-month Audit Plan to be circulated to members before coming back to the Committee in November 24 for formal presentation.                                 | Dave Harries                       | Nov 2024     | <b>Action proposed for closure</b><br><b>09.10.24</b> Dave Harries circulated the Draft Internal Audit Plan Oct 24 to March 25 to members for comment and this is being presented at the November meeting.                      |
| 17 | AC24/128.1 | 12.09.24 | <b>External Audit Progress Report</b><br>Share the Audit Wales Consultation on the Fee Scales 2025-26 with the Committee.                                                                                        | Andrew Doughton                    | Nov 2024     | <b>Action proposed for closure</b><br><b>07.10.24</b> The Audit Wales Consultation on the Fee Scales 2025-26 was shared with members outside of the meeting.                                                                    |
| 18 | AC24/129.1 | 12.09.24 | <b>Audit Wales Community Pharmacy Data Matching Pilot</b><br>Add to the forward work plan for the January 2025 meeting.                                                                                          | Pam Wenger<br>Philippa Peake-Jones | January 2025 | <b>Action proposed for closure</b><br><b>30.09.24</b> This has been included on the forward workplan for the meeting in January 2025.                                                                                           |

**Closed Actions (as agreed at meeting on 12.09.24)**

| Action No. | Minute Ref. | Date     | Agreed Action                      | Lead        | Timescale | Status                       |
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| 1          | AC24.20.1   | 12.01.24 | The Acting Board Secretary to work | Phil Meakin | March     | 05.03.24 There has been some |





|   |           |          |                                                                                                                                                                                                 |                                                                        |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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|   |           |          | with the Committee Chair, Interim Executive Director of Finance, Chief Executive and Internal Audit on progress relating to the Audit Tracker report, to provide assurances in future meetings. | Pam Wenger                                                             | 2024     | <p>significant work on this including the review of approach at the Executive Team Meeting following the last AC. A meeting is being arranged between the Executive Director of Operations and Audit Chair. A process developed with IA agreement on how to check completion.</p> <p>04.03.24 IA report produced on closed recommendations to follow at May 2024 AC.</p> <p>15.03.24 Item to be kept open – Significant work had been noted at the recent Executive Team Meeting. It was raised that an Internal Audit Report was produced on closed recommendations and the report would be provided at the AC in May 2024.</p> <p>02.09.24 Following discussion with Chair propose the action is closed as reporting will include presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item.</p> |
| 2 | AC24.39.8 | 02.03.24 | The Committee discussed the repository of learning. It was agreed to share the paper.                                                                                                           | <p>Item ref 2: March 2024</p> <p>Chris Lynes,<br/>Deputy Executive</p> | May 2024 | <p>Actions aligned (Jan 23 &amp; March 24 – items 11 &amp; 2)</p> <p>23.04.24 Associate Director of Governance contacted Deputy Exec Dir of Nursing to check complete.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



|  |  |  |  |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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|  |  |  |  | Director of Nursing | <p>26.04.24 Feedback received via Deputy Director of Quality. The specification and “wireframe” for the app has been designed and a prototype is in place. The next and current phase is to begin testing the app, which will be done with the MHLD Division. This user testing will help further refine the app through identifying any bugs or technical issues and inform enhancements from practical use by front line clinicians, prior to wider roll-out. This testing will take place over the coming quarter.</p> <p>22.05.24 Item requested for sharing.</p> <p>12.06.24 Item to be kept open – further detail requested by the Director of Corporate Governance.</p> <p>26.06.24 Confirmed that there is no paper but the detail of the repository will be covered in the Quality Paper to the Board.</p> <p>02.09.24 Matt Joyes confirmed that details of the learning portal development have been included in the Integrated Quality Report, the report was submitted to QSE Committee in August 24 and can be found in the papers via the link below (item QS24.92 – page 30 of report)</p> |
|--|--|--|--|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



|   |                          |          |                                                                                                                                    |                                                   |          | <a href="#">QSE Quality Report</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---|--------------------------|----------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3 | AC24.45.12               | 15.03.24 | The current Health & Safety Policy is overdue for review. It was agreed to follow up the urgency to update the out of date Policy. | Phil Meakin<br>Pam Wenger                         | May 2024 | <p>23.04.24 Head of H&amp;S contacted on 23.4.24 Note action owner is Assistant Director of Occupational Health and Safety. Update as follows</p> <ul style="list-style-type: none"> <li>- The responsible officer agreed an extension on this for 6 months (that lasts until June 2024). This will enable the new Exec responsibilities to be defined, as the policy has to be rewritten as the accountabilities are changing. The version is drafted ready for confirmation of accountabilities.</li> </ul> <p>22.05.24 PW reported that the Health &amp; Safety Policy is being revised and it is expected to be considered by the Board in July 2024.</p> <p>03.07.24 Health &amp; Safety Policy scheduled for People &amp; Culture Committee in August 24 and Board approval in September 24.</p> <p>02.09.24 Discussion held with CEO and Chair of Audit Committee to confirm that the policy has been included on the agenda for the Board in September 24</p> |
| 4 | AC24.46.2 &<br>AC24.46.3 | 15.03.24 | Overdue audit recommendations. A log of the recommendations for closure signed off by Internal Audit would form part of the future | Pam Wenger<br>Nesta Collingridge<br>Glesni Driver | May 2024 | 18.04.24 An update on the current position with all recommendations will be provided for the May AC, which will include a log of recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



|   |             |          |                                                                                                                                                                                                                                                          |                                                   |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                             |
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|   |             |          | reporting.<br>It was agreed to correct an error, as pointed out by the Chair, in the statistics within the report.                                                                                                                                       |                                                   |                                            | that are awaiting approval at the different stages of the approval process.<br>23.04.24 The Audit Committee will receive a report on this in May – Proposed to keep open until received and considered.<br>02.09.24 This action is linked to AC24.20.1, reporting will include presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item.    |
| 5 | AC24.46.6   | 15.03.24 | The Chair commented upon the tracker as a whole, and suggested that the Internal and External Audits be placed upon separate documents for the next financial year and it was noted that in future, the reports would be condensed and easier to manage. | Pam Wenger<br>Nesta Collingridge<br>Glesni Driver | May 2024                                   | 08.04.24 The internal and external audits recommendations will be reported separately at future Audit Committees.<br>07.05.24 Proposed to keep this open due to the need to gain assurance in the meeting.<br>02.09.24 This action is linked to AC24.20.1, reporting will include presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item. |
| 6 | AC24.61.2.4 | 07.05.24 | Structured Assessment - An Independent Member suggested that completion dates be provided within the reports, against historical recommendations where they had not                                                                                      | Pam Wenger                                        | Future report/ agenda item to be confirmed | 03.07.24 To be included on the July agenda as part of the audit tracking report and a report on progress against the Structured Assessment would be reported in September                                                                                                                                                                                                                                                   |



|    |           |          |                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |           |                                                                                                                              |
|----|-----------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------|------------------------------------------------------------------------------------------------------------------------------|
|    |           |          | been complete. The Director of Corporate Governance would provide an update to the historical recommendations at a future meeting.                                                                                                                                                                                                                                                                                                   |                 |           | 2024.<br>02.09.24 PW confirmed that this information will be included in the report going forward.                           |
| 7  | AC24.80.7 | 09.07.24 | The Chair requested clarification around the publication of the Accounts. The Director of Corporate Governance clarified that the draft accounts had been published in the public domain and the support and preparation of the Communications Team was in place. It was confirmed that the Director of Corporate Governance intended to provide support to the Communications Team in order to share the thoughts of the Committee. | Pam Wenger      | Sept 2024 | 02.09.24 The Annual Report and Accounts have been laid by the Senedd. The Annual General Meeting will take place on 25.09.24 |
| 8  | AC24.86.3 | 09.07.24 | The Director of Corporate Governance referred to 3 minor updates to the Annual Report 2023/24, which would be made prior to presentation to the Health Board. It was proposed to work with Audit Wales, to finalise the points, to address the specific issues raised.                                                                                                                                                               | Pam Wenger      | Sept 2024 | 02.09.24 The updates were referred to in the presentation at the Health Board meeting where the Board approved the accounts. |
| 9  | AC24.90.2 | 18.07.24 | It was agreed that items on the action log that were closed by the Committee would be noted in the minutes of the meeting going forward.                                                                                                                                                                                                                                                                                             | Jody Evans      | Sept 2024 | 02.09.24 Laura Jones as secretariat to the Audit Committee going forward will action this for future minutes.                |
| 10 | AC24.91.1 | 18.07.24 | It was agreed that a review of the                                                                                                                                                                                                                                                                                                                                                                                                   | Philippa Peake- | Sept 2024 | 02.09.24 This has been discussed                                                                                             |



|    |            |          |                                                                                                                                                                                                                                                                                                                                        |                                    |           |                                                                                                                                                                                                                                              |
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|    |            |          | actions from the previous meeting be reviewed and an update provided to the Chair to ensure that there were no actions missing. It was noted that the column advising of the revised deadline date was missing which was an oversight and would be reinstated.                                                                         | Jones<br>Laura Jones               |           | and the actions agreed for closure at the meeting on 18.07.24 have been noted in the action log. In relation to the additional column, going forward original timescales will have a strikethrough and a revised timescale will be included. |
| 11 | AC24.94.10 | 18.07.24 | It was agreed to share the Effective Governance – Integrated Health Community (IHC) Central Final Internal Audit Report with the Performance, Finance and Information Governance Committee.                                                                                                                                            | Philippa Peake-Jones               | Sept 2024 | 02.09.24 This item has been included on the transfer log.                                                                                                                                                                                    |
| 12 | AC24.95.7  | 18.07.24 | It was noted to arrange a future session with Board Members to further discuss the role and operations of Shared Services.                                                                                                                                                                                                             | Pam Wenger                         | Sept 2024 | 02.09.24 This has been included on the Audit Committee forward workplan and the Audit Committee Development Plan.                                                                                                                            |
| 13 | AC24.98.3  | 18.07.24 | It was confirmed that detailed work was to be undertaken in relation to the Standards of Business Conduct, with the Head of Corporate Affairs to address the recommendations and system challenges. It was noted that the Director would feedback to the Committee in relation to updates on progress in the November Audit Committee. | Pam Wenger<br>Philippa Peake-Jones | Nov 2024  | 02.09.24 A new Standards of Business Conduct policy is currently being drafted and all the relevant processes that align to the policy are being updated to ensure they are consistent. This policy will also align with the rest of Wales.  |
| 14 | AC24.102.7 | 18.07.24 | In relation to the internal / external audit tracker, concerns were raised that the report did not evidence the status in relation to medium and high                                                                                                                                                                                  | Pam Wenger                         | Sept 2024 | 02.09.24 Discussion has taken place with the Chair of the Audit Committee. Additional detail is provided in the report with more                                                                                                             |





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|  |  |  | risks and overdue items relating to limited and unsatisfactory audit reports. It was agreed the need for better insight into the status of recommendations should be included in the report. |  |  | analysis on the appendices. A presentation has been included by the Director of Corporate Governance in terms of the outstanding recommendations. |
|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------|



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| <b>Teitl adroddiad:</b><br><i>Report title:</i>           | Central IHC, formal complaints positional update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Adrodd i:</b><br><i>Report to:</i>                     | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>     | Not Applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i> | <p>This paper is to provide the Audit Committee an update in terms of the Central Integrated Health Community Performance against the 'Putting Things Right' Standards for the Management of formal Concerns.</p> <p>The members of the committee are asked to note improvements made, however there is still work to do to achieve and sustain compliance.</p> <p>In summary for Qtr 1 (April – June 2024) the overall position was 192 number of Open Complaints managed under PTR.</p> <p>By Qtr 2 (July – Sept 2024) the overall position is at 134 number of Open Complaints managed under PTR.</p> |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Argymhellion:</b><br><i>Recommendations:</i>           | The members of the committee are asked to note the report.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Arweinydd Gweithredol:</b><br><i>Executive Lead:</i>   | Angela Wood, Executive Director of Nursing and Midwifery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Awdur yr Adroddiad:</b><br><i>Report Author:</i>       | Naomi Holder, Interim Director of Nursing, Central IHC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>  | <b>I'w Nodi</b><br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>I Benderfynu arno</b><br><i>For Decision</i><br><input type="checkbox"/>                                                                                                                                                                           | <b>Am sicrwydd</b><br><i>For Assurance</i><br><input checked="" type="checkbox"/>                                                                                                                                                                |
| <b>Lefel sicrwydd:</b><br><i>Assurance level:</i>         | <b>Arwyddocaol</b><br><i>Significant</i><br><input type="checkbox"/><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>                                                                                                                                                                                                                                                                                                                                                     | <b>Derbyniol</b><br><i>Acceptable</i><br><input type="checkbox"/><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Rhannol</b><br><i>Partial</i><br><input checked="" type="checkbox"/><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> |
|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                       | <b>Dim Sicrwydd</b><br><i>No Assurance</i><br><input type="checkbox"/><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><i>No confidence / evidence in delivery</i>                                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          |
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| <p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><i>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:</i></p> |                                                          |
| Cyswllt ag Amcan/Amcanion Strategol:                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          |
| <i>Link to Strategic Objective(s):</i>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          |
| Goblygiadau rheoleiddio a lleol:                                                                                                                                                                                                                                                                                                                                                                                                             | Compliance with NHS executive/Welsh Government standards |
| <i>Regulatory and legal implications:</i>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                          |
| Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?                                                                                                                                                                                                                                                                                                                                                                           | No                                                       |
| <i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i>                                                                                                                                                                                                                                                                                                                                                       | EqlA not required as no proposed changes have occurred.  |
| Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?                                                                                                                                                                                                                                                                                                                                                                          | No                                                       |
| <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>                                                                                                                                                                                                                                                                                                                                                         |                                                          |
| Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)                                                                                                                                                                                                                                                                                                             | No new risks have been identified.                       |
| <i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i>                                                                                                                                                                                                                                                                                                        |                                                          |
| Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith                                                                                                                                                                                                                                                                                                                                                                               | No new financial implications identified                 |
| <i>Financial implications as a result of implementing the recommendations</i>                                                                                                                                                                                                                                                                                                                                                                |                                                          |
| Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith                                                                                                                                                                                                                                                                                                                                                                               | No new workforce implications identified                 |
| <i>Workforce implications as a result of implementing the recommendations</i>                                                                                                                                                                                                                                                                                                                                                                |                                                          |
| Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori                                                                                                                                                                                                                                                                                                                                                                                         | Not applicable                                           |
| <i>Feedback, response, and follow up summary following consultation</i>                                                                                                                                                                                                                                                                                                                                                                      |                                                          |
| Cysylltiadau â risgiau BAF:<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)                                                                                                                                                                                                                                                                                                                                                            |                                                          |
| <i>Links to BAF risks:<br/>(or links to the Corporate Risk Register)</i>                                                                                                                                                                                                                                                                                                                                                                     |                                                          |
| Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)                                                                                                                                                                                                                                                                                                                                                                     | Not applicable                                           |

|                                                                                                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b><i>Reason for submission of report to confidential board (where relevant)</i></b>                                                                                                                           |  |
| <b><i>Next Steps:</i></b><br>To continue with the supportive implementation of the process to manage and respond to formal concerns in line with specified timeframes, enabling the IHC to achieve compliance. |  |
| <b><i>List of Appendices:</i></b><br>1.0 Complaints compliance and trajectory data.                                                                                                                            |  |

# Complaints and Concerns Improvement

As of week commencing 29.09.24



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# IHC CENTRAL- Summary and Performance

- Number of open complaints – 134 (**Reduction** of 14 from last week- 148)
- Number of Complaints Less than 30 days – 51 (**Same as** last week- 51)
- Number of Complaints Between 31 and 180 Days – 68 (**Reduction** of 15 from last week – 83)
- Number of complaints over 180 days – 15 (**Increase** of 1 last week) - 14
- Number of Overdue complaints – 83 (**Reduction** of 14 from last week – 97)
- Number of closed complaints – 29 (**Increase** of 5 from last week – 24)
- Compliance with 75% target of overdue complaints – 38.06% **Not on Track projected to achieve 50.76%**
- Current Median Closed (Since 5<sup>th</sup> Feb) – 14.42
- Current Median Opened (Since 5<sup>th</sup> Feb) – 16
- **Target Trajectory – Minimum of 49 complaints to close between 29/09/2024 and 07/10/2024**

## Key

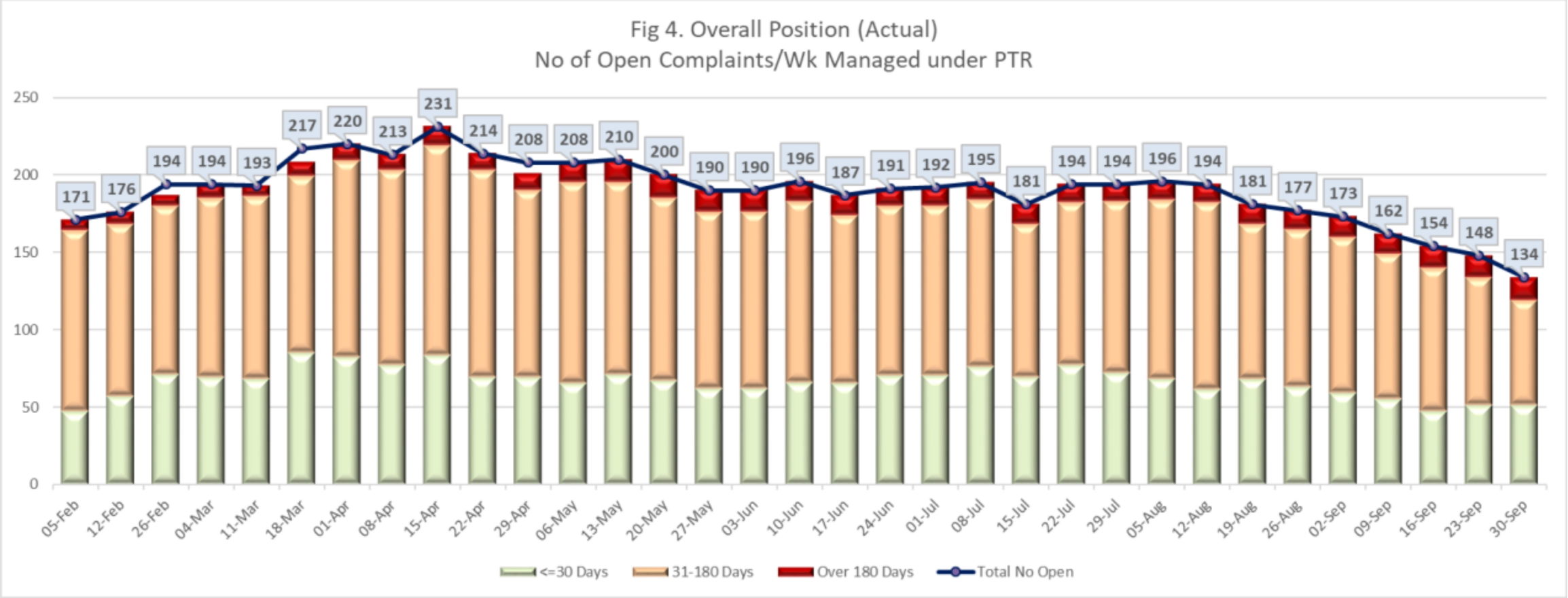
**Red** – Negative Variance (Reduction in Performance)

**Yellow** – Static Variance (Neither improvement of reduction)

**Green** – Positive Variance (Improvement in Performance)

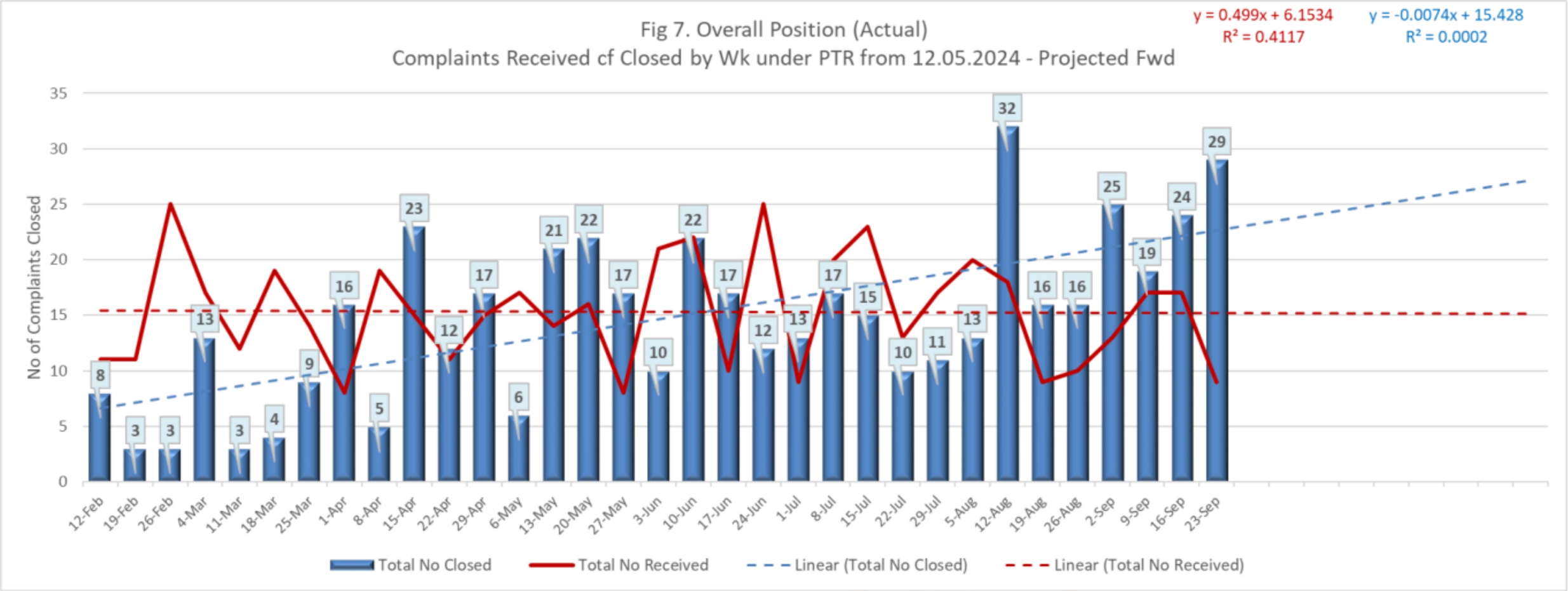


# IHC CENTRAL- COMPLAINTS





# IHC CENTRAL- COMPLAINTS CLOSED / RECIEVED



# IHC CENTRAL- COMPLAINTS

| Wk Beginning  | 02-Sep | 09-Sep | 16-Sep | 23-Sep | 29-Sep |
|---------------|--------|--------|--------|--------|--------|
| <=30 Days     | 59     | 55     | 47     | 51     | 51     |
| 31-180 Days   | 101    | 94     | 93     | 83     | 68     |
| Over 180 Days | 13     | 13     | 14     | 14     | 15     |
| Total No Open | 173    | 162    | 154    | 148    | 134    |

| Wk Beg      | 02-Sep | 09-Sep | 16-Sep | 23-Sep |
|-------------|--------|--------|--------|--------|
| No Overdue  | 114    | 107    | 107    | 97     |
| No Closed   | 25     | 19     | 24     | 29     |
| No Received | 13     | 17     | 10     | 9      |

Over the last 4 weeks  
IHC CENTRAL have

Received 49 complaints  
Closed 98 Complaints

Positive Variance = 49





|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
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| <b>Teitl adroddiad:</b><br><i>Report title:</i>           | Update report on Internal and External Audit Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Adrodd i:</b><br><i>Report to:</i>                     | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>     | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i> | <p>The purpose of this report is to provide the Audit Committee with:</p> <ul style="list-style-type: none"> <li>an update on review of Audit Reports included on Audit Tracker</li> <li>an update of the current position with regards to open recommendations, and those proposed for closure</li> <li>details of all 'no', 'unsatisfactory' or 'limited' assurance recommendations</li> <li>proposals relating to historical audit recommendations.</li> </ul>                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Argymhellion:</b><br><i>Recommendations:</i>           | <p>The Audit Committee is asked to:</p> <ul style="list-style-type: none"> <li><b>NOTE</b> the current position with regards to open recommendations, those proposed for closure, and 'no', 'unsatisfactory' and 'limited' assurance recommendations</li> <li><b>APPROVE</b> the proposals within the report relating to historical recommendations and information from TeamMate.</li> <li><b>NOTE</b> that a paper relating to external audit recommendations for closure approval will be presented to the January Audit Committee</li> <li><b>NOTE</b> that a paper relating to historical external audit recommendations will be presented to the January Audit Committee.</li> </ul> |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Arweinydd Gweithredol:</b><br><i>Executive Lead:</i>   | Pam Wenger, Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Awdur yr Adroddiad:</b><br><i>Report Author:</i>       | Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                  |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>  | <p>I'w Nodi<br/><i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <p>I Benderfynu arno<br/><i>For Decision</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                        | <p>Am sicrwydd<br/><i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                        |                                                                                                                                                                                  |
| <b>Lefel sicrwydd:</b><br><i>Assurance level:</i>         | <p>Arwyddocaol<br/><i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Derbyniol<br/><i>Acceptable</i></p> <p><input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Rhannol<br/><i>Partial</i></p> <p><input checked="" type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Dim Sicrwydd<br/><i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p> |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                 |
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| <p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>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:</i></b></p>                                                                                                      |                                                                                                                                                                                                                                                                 |
| <p>Even though a considerable amount of work has been undertaken by action owners and Executive Directors since the last Audit Committee on 12<sup>th</sup> September 2024 to ensure that all open recommendations are updated with realistic implementation dates, a number of overdue recommendations remain open, with many of these being from 'limited' or 'no' assurance reports, and of 'high' priority. As usual, guidance and support is provided to all recommendation action owners and Executive Leads by the Corporate Governance Directorate.</p> |                                                                                                                                                                                                                                                                 |
| <p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>                                                                                                                                                                   |
| <p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Compliance with Internal and External Audit requirements.</p>                                                                                                                                                                                                |
| <p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b></p>                                                                                                                                                                                                                                                                                                                                                                           | <p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups</p>          |
| <p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has a SEIA identified as necessary been undertaken?</i></b></p>                                                                                                                                                                                                                                                                                                                                                                             | <p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.</p> |
| <p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b></p>                                                                                                                                                                                                                                                              | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>                                                                                                                                                                   |
| <p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>                                                                                                                                                                                                                                                                                                                                                                                        | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>                                                                                                                                                                   |
| <p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>                                                                                                                                                                                                                                                                                                                                                                                        | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>                                                                                                                                                                   |
| <p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>                                                                                                                                                                                                                                                                                                                                                                                                        | <p>The report has been prepared following feedback from previous Executive Team and Audit Committee meetings, and ongoing discussions with Internal Audit and Audit Wales.</p>                                                                                  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <p><b>Cysylltiadau â risgiau BAF:</b><br/>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b><br/>(or links to the Corporate Risk Register)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p> |
| <p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>Not applicable</p>                                                                         |
| <p><b>Camau Nesaf:</b><br/><b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b><br/><b>Implementation of recommendations</b></p> <p>The Tracker is normally presented to each quarterly meeting of the Audit Committee, but is presented at every bi-monthly meeting at present due to partial assurance.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |
| <p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <ul style="list-style-type: none"> <li>• Appendix 1 - Summary of the rationale for closure</li> <li>• Appendix 2 - Tracker with all Open 'Unsatisfactory' Assurance Recommendations</li> <li>• Appendix 3 - Tracker with all Open 'Limited' Assurance Recommendations</li> <li>• Appendix 4 - Pre-2022 Internal Audit recommendations – TeamMate 'Closed' and 'Implemented'</li> <li>• Appendix 5 - Pre-2022 Internal Audit recommendations – TeamMate 'Other categories'</li> <li>• Appendix 6 - 2022-23 Internal Audit recommendations – TeamMate 'Closed' and 'Implemented'</li> <li>• Appendix 7 - 2022-23 Internal Audit recommendations – TeamMate 'Other categories'</li> </ul> |                                                                                               |

## **INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS**

### **1. INTRODUCTION AND BACKGROUND**

This report provides an update on the progress around both internal and external audit recommendations, and focusses on the those with 'no', 'limited' or 'unsatisfactory' assurance.

The report also provides an update and proposals on historical Internal Audit recommendations from reports published prior to 2022, and the discussions and consultation that has taken place between Corporate Governance Directorate and Internal Audit in relation to these historical recommendations.

The report also includes a copy of the Interim Executive Director of Finance's presentation on outstanding 'no', 'limited' or 'unsatisfactory' recommendations, the barriers to progress, and plans for closure.

### **2 NEWLY PUBLISHED AUDIT REPORTS**

Since the last update to the Audit Committee, only one Internal Audit recommendation from a newly published internal audit report has added to the audit tracker. There were no new Audit Wales reports published since the last update.

### **3 CURRENT POSITION**

The information below reflects the period up to 7<sup>th</sup> October 2024.

#### **3.1 Recommendations for closure approval**

Following the latest updates, the summary position is as follows:

- 52 recommendations are put forward to the Executive Management Team for closure, following approval by the respective Executive
- 43 recommendations have been updated as completed by the action owner, but are awaiting Executive closure approval prior to submission to the Executive Team.

Table 1 below provides a summary of all recommendations approved for closure by the Executive Team on 23<sup>rd</sup> October 2024, by Executive Director, together with those not approved on this occasion.

| Executive Lead                                              | Approved for closure | Awaiting approval by Executive |
|-------------------------------------------------------------|----------------------|--------------------------------|
| Executive Director Therapies and Health Science             | 5                    |                                |
| Chief Digital and Information Officer                       | 3                    |                                |
| Chief Executive                                             |                      | 12                             |
| Chief Operating Officer                                     |                      | 28                             |
| Executive Director of Nursing and Midwifery                 | 5                    |                                |
| Executive Director of Transformation and Strategic Planning | 8                    |                                |
| Interim Director MHL D                                      | 1                    |                                |
| Deputy Director of People                                   | 6                    |                                |
| Executive Medical Director*                                 |                      | 3                              |
| Director of Corporate Governance                            | 7                    |                                |
| Interim Executive Director of Finance                       | 17                   |                                |
| <b>Total</b>                                                | <b>52</b>            | <b>43</b>                      |

\* The recommendations for closure approval by the Executive Medical Director have again been submitted to the Deputy Executive Medical Directors for approval but returned stating that these are for the Executive Medical Director not a deputy.

A summary of the closure narrative for each of the recommendations is included in Appendix 1.

### 3.1.1 Recommendations awaiting Executive closure approval

There are a total of 43 recommendations submitted to Executive for approval to close, but no response received – this is due to a long-term absence, and the Interim Chief Operating Officer being new in post. However, there is some progress in this respect, and an update on this will be reported at a future meeting.

## 3.2 Open recommendations

### 3.2.1 ‘No’ assurance recommendations

The remaining two open ‘no’ assurance recommendations have now been approved for closure by the Executive Team, and will be submitted to Internal Audit for their review. There are now no open ‘no’ assurance recommendations.

### 3.2.2 ‘Unsatisfactory’ assurance recommendations

Table 2 below shows a summary of all ‘unsatisfactory’ assurance recommendation, and their status:



| Executive Lead  | 'Unsatisfactory' Assurance recs - started | 'Unsatisfactory' Assurance recs - pending | Total open 'Unsatisfactory' Assurance recs overdue original implementation date | Total 'Unsatisfactory' Assurance recs put forward for closure |
|-----------------|-------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------|
| Chief Executive | 4                                         | 0                                         | 4                                                                               | 0                                                             |
| <b>Total</b>    | <b>4</b>                                  | <b>0</b>                                  | <b>4</b>                                                                        | <b>0</b>                                                      |

The recommendations above relate to the Operating Model. Work is progressing in this area and these recommendations are being incorporated into the work led by the Chief Executive.

A copy of the live tracker, which includes all open high priority - 'unsatisfactory' assurance reports is included in Appendix 2.

### 3.2.3 'Limited' assurance recommendations

Table 3 below shows a summary, by Executive, of all 'limited' assurance recommendations, and their status, including historical (pre-2022) recommendations:

| Executive Lead                                              | 'Limited' Assurance recs - started | 'Limited' Assurance recs - pending* | Total open 'Limited' Assurance recs overdue original implementation date | Total 'Limited' Assurance recs put forward for closure |
|-------------------------------------------------------------|------------------------------------|-------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| Interim Executive Director of Finance                       | 1                                  | 1                                   | 1                                                                        | 9                                                      |
| Director of Performance on Commissioning (when in post)     | 13                                 | 0                                   | 13                                                                       | 0                                                      |
| Chief Executive                                             | 7                                  | 7                                   | 13                                                                       | 0                                                      |
| Executive Director of Transformation and Strategic Planning | 0                                  | 6                                   | 4                                                                        | 0                                                      |
| Executive Medical Director                                  | 0                                  | 19                                  | 19                                                                       | 0                                                      |
| Director of Corporate Governance                            | 7                                  | 0                                   | 3                                                                        | 6                                                      |
| Deputy Director of People                                   | 1                                  | 0                                   | 1                                                                        | 0                                                      |
| Chief Operating Officer                                     | 25                                 | 17                                  | 27                                                                       | 0                                                      |
| Executive Director of Nursing and Midwifery                 | 17                                 | 0                                   | 6                                                                        | 4                                                      |
| Acting Executive Director of Public Health                  | 0                                  | 9                                   | 9                                                                        | 0                                                      |
| Previous Executive (historical recommendations)             | 0                                  | 2                                   | 2                                                                        | 0                                                      |
| Executive Lead to be decided                                | 8                                  | 0                                   | 8                                                                        | 0                                                      |
| <b>Total</b>                                                | <b>79</b>                          | <b>61</b>                           | <b>106</b>                                                               | <b>19</b>                                              |

\* A number marked 'pending' have retrospectively been added to the tracker, and therefore no request for updates made due to this.

A copy of the live tracker, which includes all open high priority - 'limited' assurance reports is included in Appendix 3.

All recommendations awaiting closure approval from the Executive are also included within the above totals.

#### 4 SUMMARY OF ALL RECOMMENDATIONS

Table 4 provides information as to number of ALL recommendations, per status, whether newly added to the tracker and being progressed, through to those in the differing stages of closure approvals.

|                                                                                                          | As at<br>30/06/2024 | As at<br>31/08/2024 |
|----------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| Newly added Internal Audit recommendations                                                               | 19                  | 1                   |
| Newly added Audit Wales recommendations                                                                  | 0                   | 0                   |
| Open - historical and ongoing recommendations                                                            | 337                 | 193                 |
| Open - historical recommendations pending closure approval, as per report proposals                      | -                   | 427                 |
| Pending - for Executive approval                                                                         | 16                  | 43                  |
| Pending - received Executive Team approval on 23/10/2024, now for Internal Audit review (if appropriate) | 81                  | 55                  |
| Pending - currently with Internal Audit for review                                                       | 86                  | 0                   |
| Pending - approved for closure by Internal Audit                                                         | 69                  | 1                   |
| Pending - further work required by Health Board following Internal Audit review                          | 19                  | 50                  |
| Pending Audit Wales closure approval                                                                     | 34                  | 8                   |
| Pending Audit Committee approval                                                                         | 53                  | 77                  |

#### 5 AUDIT COMMITTEE PRESENTATIONS

As per the action from the last Audit Committee on 12<sup>th</sup> September 2024, the Interim Executive Director of Finance has prepared a presentation on all outstanding his recommendation with 'no', 'unsatisfactory' and 'limited' assurance for presentation to the Audit Committee on 5<sup>th</sup> November 2024.

However, since the last Audit Committee, the Interim Executive Director of Finance now has only 1 open 'no' assurance recommendation, with two 'limited' assurance recommendation, one started, the other pending.

## 6 HISTORICAL RECOMMENDATIONS – PRE-2022

As has previously been reported, the Health Board was able to obtain a copy of the information included within the TeamMate system - the audit tracking system in use by the Health Board at that time to capture recommendations, prior to ceasing its use in late 2023. Within that TeamMate update, each Internal Audit and Audit Wales recommendation was categorised at different approval stages, and Internal Audit have confirmed that the below were the different approval categories used at that time:

| Approval stage                        | Internal Audit description of recommendation stage                                                                                                                                                                                                                               |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Closed - Mgt Accepts Risk             | Can be closed on the tracker                                                                                                                                                                                                                                                     |
| Closed - No Longer Applicable         | Can be closed on the tracker                                                                                                                                                                                                                                                     |
| Closed - Not Verified                 | No verification as closed by the Audit Committee but not verified by IA as outside IA scope                                                                                                                                                                                      |
| Closed - Verified                     | Closed by IA following verification                                                                                                                                                                                                                                              |
| Implemented                           | This has not been subject to any review and only signed off by a Contributor not the Owner and awaits Executive approval                                                                                                                                                         |
| Implemented - Audit Approved          | Closed by the Audit Committee but not verified by IA. Any limited/No assurance reports require review by IA but this has not happened yet. IA would review them and then would assign 'Closed - verified' or 'Closed - not verified' if it was outside the scope of IA follow-up |
| Implemented - Final Client Approved   | Exec has approved after the Owner has confirmed complete                                                                                                                                                                                                                         |
| Implemented - Partial Client Approved | Owner has confirmed implemented and an email has been sent to the Executive asking them to approve and move it to Final Client Approved stage - Awaiting Executive Director approval                                                                                             |

All recommendations and associated information contained within the TeamMate update has now been transferred into the live tracker, some pre-dating 2022.

It is appreciated that there are a number of additional appendices within this report, but they are included for transparency. As we move forward, there will not be this level of detail or number of appendices in future reports.

### 6.1 Pre-2022 recommendations marked as closed

In line with the approval process in place at that time, the following Internal Audit recommendations were deemed as 'closed', and the recommendation completed on the TeamMate system:

- Closed - Mgt Accepts Risk
- Closed - No Longer Applicable
- Closed - Not Verified
- Closed - Verified
- Implemented - Audit Approved

Appendix 4 shows all the Internal Audit recommendations in the above categories, sorted by category, with the corresponding updates on progress/completion from TeamMate.

**Proposal 1:** It is proposed that all the pre-2022 recommendations recorded in the above five categories on TeamMate are closed on the live audit tracker, with no further action required. This is because the implementation work was carried out at that time, and the recommendation previously approved for closure by Audit Committee. The Audit Committee is therefore asked to **approve** this proposal.

## 6.2 Pre 2022 recommendations – other

From the TeamMate information, those Internal Audit recommendations listed within the following approval categories remained at differing stages of implementation, and not closed under the historical process:

- Implemented – Final Client Approved
- Implemented - Partial Client Approved
- Started
- No categorisation

Due to the historical nature of many of these recommendations, it is likely that they are outdated or superseded. Therefore, the work required to source updates on progress, and evidence to support closure for recommendations that have already been implemented under the historical process would be inefficient and ineffective, and divert the focus away from implementing more current and appropriate recommendations. However, some of these are still be valid, and work still required to implement changes.

Appendix 5 shows all the Internal Audit recommendations in the above implementation stages, sorted by category. All the narrative around the progress of each recommendation at that time has been transposed from the TeamMate information onto the live tracker, and can be seen in Appendix 5.

Internal Audit have reviewed all their recommendations, and have provided their audit category for those that fall within the Audit Charter, and narrative around their rationale for that categorisation. A number have been approved for closure, others will need the Executive to review to ensure they can be put forward for closure, and Internal Audit will want to see evidence relating to others. This information is included in the last two columns of Appendix 5a.

**Proposal 2:** Consultation has already taken place with Internal Audit in relation to the closure of historical recommendations, therefore it is proposed that the pre-2022 Internal Audit recommendations included in Appendix 5 are actioned in line with the Internal Audit review – this will be either closure, review by Executive or sourcing of evidence to support closure. It is also proposed that those recommendations not reviewed by Internal Audit due to being outside the terms of the Audit Charter be put forward for closure.

Therefore, the Audit Committee is asked to **approve** this proposal.

## 7 HISTORICAL RECOMMENDATIONS – 2022/2023

From the information included within the TeamMate system, there were also updates relating to recommendations from 2022/23 that had also been progressed to different stages of implementation at that time. Within that TeamMate update, each Internal Audit was categorised at the different approval stages – see section 6 above for categorisation detail.

### 7.1 2022/23 Internal Audit recommendations marked as closed/implemented

From the TeamMate information, there are two Internal Audit recommendations categorised as 'Closed – Verified' or 'Implemented', and the details, including the narrative from TeamMate is included in Appendix 6.

**Proposal 3:** As the work to implement these recommendations has already taken place, and previously approved by Internal Audit, it is proposed that these recommendations be closed on the live tracker.

The Audit Committee is therefore asked to **approve** this proposal.

### 7.2 Pre 2022 Internal Audit recommendations – other

From the TeamMate information, there are a number of 2022/23 Internal Audit recommendations listed within the following approval categories:

- Implemented – Final Client Approved
- Implemented - Partial Client Approved
- Started
- No categorisation

Due to the historical nature of many of these recommendations, it is likely that they are outdated or superseded. Therefore, the work required to source updates on progress, and evidence to support closure for recommendations that have already been implemented under the historical process would be inefficient and ineffective, and divert the focus away from implementing more current and appropriate recommendations. However, some of these are still be valid, and work still required to implement changes.

Appendix 7 shows all the Internal Audit recommendations in the above implementation stages, sorted by category. All the narrative around the progress of each recommendation at that time has been transposed from the TeamMate information onto the live tracker, and can be seen in Appendix 7.

Internal Audit have reviewed all their recommendations, and have provided their audit category for those that fall within the Audit Charter, and provided narrative around their rationale for that categorisation. A number have been approved for closure, and others will need the Executive to review to ensure they can be put forward for closure. This information is included in the last two columns of Appendix 7.

**Proposal 4:** Internal Audit has been consulted in relation to the closure of historical recommendations, therefore it is proposed that the 2022/23 Internal Audit recommendations included in Appendix 7 are actioned in line with the Internal Audit review – this will be either closure, or review by Executive. It is also proposed that those recommendations not reviewed by Internal Audit due to being outside the terms of the Audit Charter be put forward for closure.

Therefore, the Audit Committee is asked to **approve** this proposal.

## **8 AUDIT WALES RECOMMENDATIONS**

### **8.1 Recommendations for closure approval**

An update on external audit recommendations that have been through the Health Board approval process will be presented to the next Audit Committee for final closure approval.

### **8.2 Historical external audit recommendations**

A separate paper on progress against historic external audit recommendations will be presented at the January Audit Committee.

## **9 CONCLUSION AND RECOMMENDATIONS**

The work to close historical recommendations will ensure that the live tracker only includes recommendations from audit reports that are still valid and relevant, and in line with this, that there is an appropriate approval process for the closure of all those historical recommendations.

Once the live tracker has been cleansed, this will ensure that only those valid and relevant recommendations are transferred to a new electronic audit tracking system once identified, and the work to look at options around this system can then continue.

## **10 BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

Resources for progressing the work around the audit recommendations lie with the relevant directorate, division, or department as part of business-as-usual functions.

## **11 RISK MANAGEMENT**

It is essential that the Health Board progresses work around the audit recommendations as a matter of urgency, and in line with the published implementation dates in order to minimise risks associated with those areas of work.

There are risks to the Health Board relating to audit recommendations as they highlight areas of improvement required by the Health Board, and more so for those that are overdue their original implementation date. Due to this, Director of Corporate Governance holds an overarching Health Board risk on Datix relating to this.

## 12 **EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, Equality and Diversity compliance should be considered by each recommendation owner and Executive Director lead when implementing changes to processes and procedures in line with the requirements of the audit reports.



**APPENDIX 1 - SUMMARY OF THE RATIONALE FOR CLOSURE**

**APPENDIX 2 - TRACKER WITH ALL OPEN 'UNSATISFACTORY' ASSURANCE RECOMMENDATIONS**

**APPENDIX 3 - TRACKER WITH ALL OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS**

**APPENDIX 4 – PRE-2022 INTERNAL AUDIT RECOMMENDATIONS – TEAMMATE 'CLOSED' AND 'IMPLEMENTED'**

**APPENDIX 5 – PRE-2022 INTERNAL AUDIT RECOMMENDATIONS – TEAMMATE 'OTHER CATEGORIES'**

**APPENDIX 6 – 2022-23 INTERNAL AUDIT RECOMMENDATIONS – TEAMMATE 'CLOSED' AND 'IMPLEMENTED'**

**APPENDIX 7 - 2022-23 INTERNAL AUDIT RECOMMENDATIONS – TEAMMATE 'OTHER CATEGORIES'**

## SUMMARY OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE

APPROVED BY EXECUTIVE TEAM ON 23/10/2024

### Summary of recommendation with rationale for closure

#### EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY

|   |     |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---|-----|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | 320 | Lessons Learnt                                  | The policy was approved at the Board in July 2024 and is being implemented on 01 Sept 2024.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 2 | 324 |                                                 | Meeting arranged between Head of Quality and Head of Clinical Effectiveness where it was confirmed and evidenced that learning is cascaded/shared through the clinical effectiveness quarterly reports and the recent Annual Report, and captured on the clinical effectiveness web page. Information shared with Strategic Clinical Effectiveness Group and also QDG, with reference made to QSE and Board.                                                                                                                                                                                                                                        |
| 3 | 354 | Deprivation of Liberty Safeguards (DoLS) - 2024 | Pull-up posters and wall posters have been delivered to the three DGH's and other sites, with further and ongoing promotion planned across the Health Board, to include attendance at various training events, conferences and activities during safeguarding week in November.                                                                                                                                                                                                                                                                                                                                                                     |
| 4 | 355 |                                                 | Reporting and escalation of MCA compliance and non-compliance into the MHLC is in place. Review of MCA training a standard agenda item at all Safeguarding Forums. Monitoring in place via the Forum. Assurance and further activity recorded at SGPG and QDG.                                                                                                                                                                                                                                                                                                                                                                                      |
| 5 | 497 | Effective Governance – Women's Directorate      | Review of Women's Service Senior Leadership Team TORs undertaken by Director of Corporate Governance, and updated to ensure that the purpose of meetings and assurance flows through to the Senior Leadership Team are clearly defined. These were approved by the Women's Service Board on 23rd August 2024. The following Womens Services meetings sit at Tier 2 that will now follow the review process of the TORs: Womens Transformation Group (SDG) - Quarterly; Womens Quality, Safety and Experience Group (SDG) (Inc H&S) - Monthly; Womens Integrated Performance Group (SDG) - Monthly; Womens People and Culture Group (SDG) - Monthly. |

#### CHIEF DIGITAL AND INFORMATION OFFICER

|   |     |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---|-----|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | 486 | CITO Programme          | Further meeting took place with the Clinical leads in August presenting the recommendation on the optimisation of the 4 clinical system, Cito/Epro/WCP and EPOC. The outcome of this meeting included the future use of WCP as the main clinical system, and all process should be tried and tested within WCP before utilising any other local system. It was agreed that CITO would be used as an Electronica Document Management System (EDRMS) and further work is needed to establish how eForms should be created and stored. It recommended that work be undertaken to establish the route to decommission EPOC and establish the correct applications to replace the functionality. It was recommended and agreed that EPRO will be used as a Digital Dictation system only in accordance with the current license agreement. It was also agreed that a full audit be undertaken on the system to understand the extent of use beyond the current agreement. It was agreed that the resources for this work will be the current CITO Programme team. |
| 2 | 530 | Digital Operating Model | The Office of the CCIO now has a list of individuals who can be contacted in each clinical department across BCU.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 3 | 535 |                         | In-year ESP budget has been committed as planned and will provide limited levels of replacement technologies restricted to Core LAN and End User Devices. Opportunities may arise to further this if any WG Capital becomes available. It is unlikely that the allocation for the next financial year will change unless more discretionary Capital comes available to BCU. ESP Revenue situation remains unchanged. Current estimates are that the desktop estate will be c.3,000 devices short of that required to achieve Windows 11 when Windows 10 ceases to have security patch support.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

#### DEPUTY DIRECTOR OF PEOPLE

|   |     |                            |                                                                                                                                                                                                                                                                                                                           |
|---|-----|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | 448 | Taking Care of the Carers? | The All Wales Risk Assessment tool was deployed in BCUHB and was embedded as part of ESR compliance monitoring as an all staff requirement to complete.                                                                                                                                                                   |
| 2 | 449 |                            | Since the COVID pandemic BCUHB have implemented a suite of BI dashboard metrics that help identify workforce capability, capacity and staffing gaps more easily. In addition, a new culture dashboard has been launched, alongside a culture change programme overseen by the Culture Steering Group, chaired by the CEO. |
| 3 | 450 |                            |                                                                                                                                                                                                                                                                                                                           |
| 4 | 451 |                            |                                                                                                                                                                                                                                                                                                                           |
| 5 | 452 |                            |                                                                                                                                                                                                                                                                                                                           |
| 6 | 645 | Roster management          | Revised policy is now live with all relevant amendments enacted.                                                                                                                                                                                                                                                          |

| DIRECTOR OF CORPORATE GOVERNANCE |      |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------|------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                                | 1251 | Risk Management - June 2022                                                                 | The escalation route is now to RSG, comms have been sent to directors on how risks need to be escalated and strategic risk management training has been booked across all three sites to further communicate this message and route to escalation. RM02 is now live.                                                                                                                                       |
| 2                                | 1275 | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. Scheduled notifications in place, go out monthly and are monitored.                                                                                                                                                                                                                             |
| 3                                | 1276 |                                                                                             | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. Monthly published data reviewed to ensure accuracy and reconciled with source data.                                                                                                                                                                                                             |
| 4                                | 1277 |                                                                                             | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. NHS England logo changed by Civica to the NHS Wales logo.                                                                                                                                                                                                                                       |
| 5                                | 1278 |                                                                                             | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. Updated cycle of business submitted to the Audit Committee twice a year.                                                                                                                                                                                                                        |
| 6                                | 1279 |                                                                                             | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. The Declarations of Interest mailbox is monitored on an almost daily basis, and actioned as necessary.                                                                                                                                                                                          |
| 7                                | 1280 |                                                                                             | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. Regular communications are sent via the intranet, and line managers are requested to authorise all Declarations. Further communication will take place when the policy goes live. Board Members were all written to as part of the Annual Report work, and their declarations were all updated. |

| EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING |     |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------|-----|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                                                           | 621 | Continuing Healthcare Arrangements                           | This work has been concluded and is now embedded across the IHCs, MH&LD. The range of supporting documentation is now available on the intranet for all staff to access. Checklist process has been subject to recent scrutiny and a training module has been development and is in the process of being implemented. Documentation developed within the HB has been <u>shared nationally and elements adopted by other HBs.</u>                                                                                                                                                                      |
| 2                                                           | 622 |                                                              | A full training programme was developed following issuing the Framework in 2022. The training is available at varying levels from introduction / awareness to practitioners and is available to HB staff and Social services. Training records are available, as well as a yearly programme of training. In addition bespoke training is available on request. Monitored as part of core business (CHC Operational group)                                                                                                                                                                             |
| 3                                                           | 623 |                                                              | The Disputes process has been formalised and implemented. This has been signed off by the IHCs, MH&LD, and social services. We are currently undertaking the annual review and reminding all partners that the Disputes process is in place and must be adhered to. This is part of the core business of the CHC ops group and has recently been discussed at NWASH.                                                                                                                                                                                                                                  |
| 4                                                           | 624 |                                                              | A full training programme was developed following issuing the Framework in 2022. The training is available at varying levels from introduction / awareness to practitioners and is available to HB staff and Social services. Training records are available, as well as a yearly programme of training. In addition bespoke training is available on request. Monitored as part of core business (CHC Operational group)                                                                                                                                                                             |
| 5                                                           | 625 |                                                              | Over the past two years that has been a comprehensive programme to ensure Boardcare is embedded across the HB. The backlog of records has been concluded, and the HB review functionality with the provider annually and develop the system to support service change e.g. Red Flags to identify providers in escalation. Training and awareness sessions continue. There is now a recommendation that all HBs adopt Broadcare, this is a recommendation of the All Wales Value and Sustainability Group.                                                                                             |
| 6                                                           | 743 | Primary Care GP Leases: Assigning leases to the Health Board | This is a historical recommendation, approved for closure by the Executive Director of Transformation and Strategic Planning - this is a really old one and relates to an internal audit of the Health Boards approach to transitioning independent practices into Health Board management                                                                                                                                                                                                                                                                                                            |
| 7                                                           | 868 | Continuing Healthcare Arrangements                           | Confirmation was given by the Executive Director Transformation and Strategic Planning that he will remain the executive lead for Corporate CHC subject to any later/further review of Executive portfolios. An Acting Assistant Director for Care Homes and CHC Commissioning has been appointed, which has been extended to December 2024 to ensure continuity and <u>leadership for the corporate team.</u>                                                                                                                                                                                        |
| 8                                                           | 876 | Review of Eye Care Services                                  | Through the revised approach to “taking a managed approach to change” that has been through the Executive Team over the last few months, the Portfolio Office within the T&I team is approaching all official programmes of work across the organisation, to feed their progress and impact into a central view of the change portfolio. The T&I team is also conducting a review of the business case process, with a view to create a single unified business case process, which will include gateway reviews that mitigate for business cases, receiving the money and not delivering the impact. |

## INTERIM EXECUTIVE DIRECTOR OF FINANCE

|    |      |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----|------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1  | 203  | Delivery of Health Board Savings                                     | Work has progressed well on identifying opportunities and converting them to Green schemes. At Month 5, the forecast value of Green Schemes totals £42.4m (including £36.8m Savings and £5.1m Accountancy Gains), an increase of £8.0m from Month 4. Of these, £27.7m have been identified as recurring, with a full year effect of £38.2m, and £14.7m are non-recurring savings. A dedicated Programme Director from the Transformational Team has been assigned to Value and Sustainability and commenced in the role on the 01/09/2024; they will be supported by a Band 8 and a Band 7. The Value and Sustainability approach to identifying savings opportunities will ensure future identification and delivery of Transformational Savings.                                                                                                                                                                                                                                                                                          |
| 2  | 521  |                                                                      | In 2023/24, the Health Board exceeded the recurring savings requirement of £25.2m, with delivery of £26.2m. To date in 24/25, against the requirement to delivery £48m of recurring savings, forecast delivery is £38.2m. The recurring delivery position against the planned savings target is clearly articulated within the Monthly Finacne Reports to PFIGC and Board which are widely available.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 3  | 221  | Follow up – Audit Wales: Effectiveness of Counter Fraud Arrangements | Re-banding of Deputy Head of Counter Fraud post accepted and submitted to payroll. Paper on future services presented through the Executive Directors of Finance All Wales meeting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 4  | 317  | Decarbonisation                                                      | Decarbonisation Action Plan (DAP) and Programme Progress Paper presented to the Partnerships People and Public Health Committee on 20th August                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 5  | 334  | Water Safety                                                         | Meeting went ahead in West with no issues reported. Item to be closed, minutes supplied for closure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 6  | 340  |                                                                      | The training programme has been implemented within all 3 areas.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 7  | 343  |                                                                      | A meeting has taken place with the EPRR lead and the Head of Operational Estates. The EPRR plan was discussed at HB 26/09/24 in a private session of which this item is related and combined.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 8  | 344  |                                                                      | Welsh Water have attend YGC/YG and created a resilience plan which will be adopted on the YG site.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 9  | 382  | Structured                                                           | Plan monitoring has moved over to the Transformation Team since April 2023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 10 | 393  | Assessment 2022                                                      | The “Our Digital Future” Strategy 2021-2024 has concluded, and a revised Digital Roadmap is being developed for the years ahead which will be full costed at an strategic and outline level.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 11 | 659  | Waste Management                                                     | Training is now live on ESR for all users under the code 000 NHS WALES - ENVIRONMENTAL, WASTE & ENERGY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 12 | 1199 | Wrexham Maelor                                                       | Russell Caldicott confirmed as SRO. Daniel Eyre confirmed as interim PD in lieu of Director of Environment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 13 | 1205 | Continuity Phase 1                                                   | The new SES frameworks covering cost advisor will be available during October 2025 . This will mitigate the previous issue.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 14 | 1302 | Budgetary Control                                                    | A meeting took place with Internal Audit on 26th July 2024 to discuss the managemnt action and recommendation.The budget holder handbook is on the intranet and available for all budget holders and finance staff. It is regularly updated and is a key source of information for budget holders. A review of the budget holder's handbook is undertaken on a periodical basis. A review of another HB budgetary control procedure has confrmed the handbook utilised by BCUHB encompasses other examples and provides more detailed and interactive content for budget holders. The handbook will remain accessssible for budget holders and will be updated as required.                                                                                                                                                                                                                                                                                                                                                                 |
| 15 | 1304 |                                                                      | Working with Internal Audit, Counter Fraud and CFOs, a new Local Finance SOP has been developed and has now been approved by the Senior Finance Team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 16 | 1305 |                                                                      | A SOP has been circulated through CFOs, with responses requested by COP 30/9/24. The SOP has been adopted for use from 01/10/24.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 17 | 1307 |                                                                      | Two further training sessions have taken place in September taking the total number of budget holders trained to 220. Further sessions are scheduled for October and December. A rolling programme of training has been developed delivered jointly by NWSSP Procurement and Finance – 220 staff have been reached so far this year. Previous updates have confirmed that the Executives have received training and a new appointments will receive this as part of their Induction Programme. The training delivery has been reported to Audit Committee members and Performance, Finance and Information Governance Committee (PFIGC), Health Board and Welsh Government. An update is now being incorporated in the Conformance Report. The distribution of the Accountability Letters to Budget Managers is assisting with attendance, due to the inclusion of the responsibility of the Divisional Director to ensure Budget managers have attended the training session. To date, 147 of those individuals have attended the session. |

## INTERIM DIRECTOR OF MHLD

|   |     |                                                |                                                                                                                                                                                                                                                                              |
|---|-----|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | 207 | Mental Health & Learning Disabilities Division | Mental Health Summit meetings were stood down in April 2023, and update from the last meeting minutes confirmed by the Executive Medical Director were that the Summit would be stood down and the discussions held via normal governance and special measures arrangements. |
|---|-----|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| EXECUTIVE DIRECTOR OF THERAPIES AND HEALTH SCIENCE |     |                 |                                                                                                                                             |
|----------------------------------------------------|-----|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1                                                  | 331 | Adult and Older | The Project Board receives regular updates. The next Programme Board is in July 2024.                                                       |
| 2                                                  | 509 | Persons Mental  | Contracts and instructions completed                                                                                                        |
| 3                                                  | 510 | Health Unit     | Contracts completed                                                                                                                         |
| 4                                                  | 511 |                 | Electronic sign off of all AOPMHU user group areas has been achieved.                                                                       |
| 5                                                  | 512 |                 | Noted all conditions for planning applications to be considered as part of design team meeting, and escalated to project board if required. |

ALL OPEN 'UNSATISFACTORY' RECOMMENDATIONS

| ID  | Internal Audit/<br>Audit Office | Report Title    | Year | Assurance Level | Priority | Recommendation Title                                                                         | Recommendation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Action Owner                                 | Final Approver                    | Recommendation State | Original implementat<br>ion date | Revised implementat<br>ion date | Number of Revisions | Latest update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| 454 | Internal Audit                  | Operating Model | 2024 | Unsatisfactory  | High     | Matter Arising 1: Operating Model (Design and Operation)                                     | 1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured. | The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability. In April 2024, this process is near conclusion. A number of new roles have been advertised publicly on agreed job descriptions and JESP banding with the Welsh Government. These roles will be interviewed in May 2024                                                                                                                                                                                                      | Jason Brannan, Deputy Director of People     | Carol Shillabeer, Chief Executive | Started              | 31/05/2024                       | 31/03/2025                      | 1                   | We are still actively recruiting for a number of vacant executive posts. Unfortunately, salary constraints have hindered progress making the Health Board less competitive in the current labour market. The Health Board continues to work with WG to address this.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 455 | Internal Audit                  | Operating Model | 2024 | Unsatisfactory  | High     | Matter Arising 1: Operating Model (Design and Operation)                                     | 1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured. | Arana (external consultancy) was commissioned in November to undertake an initial review of the operating model. The Chief Executive, supported by the Senior Associate Director of People in May 2024, will commence an engagement process with the Board and other colleagues to consider changes to the organisational structure. This will take account of the gaps in assurance that have been identified as part of this internal audit.                                                                                                | Jason Brannan, Deputy Director of People     | Carol Shillabeer, Chief Executive | Started              | 30/06/2024                       | 31/03/2025                      | 1                   | A Discovery (insights) phase report is currently being finalised. This report contains feedback from the following sources:<br>● Feedback from the Arana Stocktake with senior IHC/other colleagues. (This work was undertaken in August 2023, and included 20 colleagues feedback).<br>● Feedback from the Arana Focus groups and Survey. (This work was undertaken in May 2024 where over 250 staff were asked to attend online focus groups facilitated by Arana. All staff were also encouraged to take part in a short online survey asking the same questions as the facilitated sessions.<br>● A report from NHS Wales Shared Services Partnership Internal Audit service on their review of operating model (structures) which particularly focused on cost and benefits realisation.<br>● Feedback and insights from Independent Reviews related to escalation of the organisation into level 5 - Special Measures.<br>● Feedback and insights from national bodies/functions networks generated as a result of their work with the Health Board. Once finalised the report will be made available to the wider organisation. Once circulated we will move into the Design Phase of the Operating model review. |
| 456 | Internal Audit                  | Operating Model | 2024 | Unsatisfactory  | High     | Matter Arising 1: Operating Model (Design and Operation)                                     | 1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured. | Areas that have been identified as 'in design' will be considered as part of the wider review noted above, given there may be changes within the structure going forward. Stronger Together was the initial project that supported the change in organisational structures. To ensure we have an integrated approach going forward, a review will take place of the stronger together team and OD team. It is proposed that these teams be merged into one team to provide support to the implementation of any new organisational structure. | Carol Shillabeer, Chief Executive            | Carol Shillabeer, Chief Executive | Started              | 30/06/2024                       | 31/12/2024                      | 1                   | Suggested change the action owner to the CEO. This work is in progress and the Operating Model Discovery phase is complete. The CEO will now take the findings forward to Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 457 | Internal Audit                  | Operating Model | 2024 | Unsatisfactory  | High     | Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation) | The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | As part of the organisational structure review, all accountability frameworks will be reviewed                                                                                                                                                                                                                                                                                                                                                                                                                                                | Pam Wenger, Director of Corporate Governance | Carol Shillabeer, Chief Executive | Started              | 30/06/2024                       | 31/12/2024                      | 1                   | The post of Director of Environment and Estates remains unfilled, out to agency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

ALL 'OPEN' LIMITED RECOMMENDATIONS

| ID  | Internal Audit/<br>Audit Office | Report Title                                                             | Year | Assurance Level | Priority | Recommendation Title                                         | Recommendation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Action Owner                                              | Final Approver                                            | Original implementat<br>ion date | Revised implementati<br>on date | Number of Revisions | Latest update                                                                                                                                                                                                                                                                            |
|-----|---------------------------------|--------------------------------------------------------------------------|------|-----------------|----------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|----------------------------------|---------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 150 | Internal Audit                  | Nursing Roster Management: Introduction of e-timesheets for Agency staff | 2022 | Limited         | Medium   | Matter Arising 1: Policies and Procedures (Operation)        | 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.                                                                                                                                                                                                                                                                                                                                                              | 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. 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. 1.3 Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.                                                                                                                                                                                                                                                                                             | Clair Tipton, Head of Digital Systems                     | Jason Brannan, Deputy Director of People                  | 31/07/2022                       | 30/06/2024                      | 3                   | Action ongoing                                                                                                                                                                                                                                                                           |
| 158 | Internal Audit                  | On-Call arrangements                                                     | 2022 | Limited         | High     | Matter Arising 1 – Review of on-call arrangements (Design)   | 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. | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Unknown at present                                        | Unknown at present                                        | 23/09/2022                       | 01/06/2024                      | 3                   | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report                                                                                                                                                                         |
| 159 | Internal Audit                  | On-Call arrangements                                                     | 2022 | Limited         | High     | Matter Arising 2 – Rota guidance / sustainability (Design)   | The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; 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.                           | 2.1: On-call document, covering the recommendations above will be issued to all staff.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Unknown at present                                        | Unknown at present                                        | 01/07/2022                       | 01/06/2024                      | 1                   | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report                                                                                                                                                                         |
| 160 | Internal Audit                  | On-Call arrangements                                                     | 2022 | Limited         | High     | Matter Arising 3 – Compensatory rest and payment (Operation) | Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. 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.                                                                                                              | 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. <i>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.</i>                                                                                                                                                                                                                                                                                                             | Unknown at present                                        | Unknown at present                                        | 11/07/2022                       | 01/06/2024                      | 1                   | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report                                                                                                                                                                         |
| 161 | Internal Audit                  | On-Call arrangements                                                     | 2022 | Limited         | High     | Matter Arising 4 – Training (Design)                         | 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.                                                                                            | 4.1a: Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Unknown at present                                        | Unknown at present                                        | 28/09/2022                       | 01/06/2024                      | 1                   | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report                                                                                                                                                                         |
| 261 | Internal Audit                  | Contracted Patient Services: Quality and Safety Arrangements             | 2023 | Limited         | High     | Matter Arising 1: Process management (Design)                | 1.1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.                                                                                                                                                                                                       | 1.1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider.<br><i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i> | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 31/07/2023                       | 30/09/2024                      | 2                   | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged. |



|     |                |                                                              |      |         |        |                                                           |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                           |            |            |   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| 262 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 2: Contractual obligations (Design)        | 2.1.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement. | 2.1.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                                             | Stephen Powell, Director of Performance and Commissioning                                 | Stephen Powell, Director of Performance and Commissioning | 31/08/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 263 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 3: Quality measures (Operation)            | 3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.                                                                                                                            | 3.1.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                                                                                                                                                     | Stephen Powell, Director of Performance and Commissioning                                 | Stephen Powell, Director of Performance and Commissioning | 31/08/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 264 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 3: Quality measures (Operation)            | 3.2.1: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.                                                                                                | 3.2.1: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i> | Stephen Powell, Director of Performance and Commissioning                                 | Stephen Powell, Director of Performance and Commissioning | 31/10/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 265 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 4: Board assurance (Design)                | 4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.                                                              | 4.1 1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                | Stephen Powell, Director of Performance and Commissioning                                 | Stephen Powell, Director of Performance and Commissioning | 31/10/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 298 | Internal Audit | Falls Management                                             | 2023 | Limited | High   | Matter Arising 3: Training (Operation and Design)         | 3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.                                                                        | 3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.                                                                                                                                                                                                                                                                                                     | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security | Angela Wood, Executive Director of Nursing and Midwifery  | 01/01/2024 | 30/09/2024 | 2 | A full review of the BCUHB business model aligned to the All Wales NHS Manual Handling Passport Scheme 2020 is underway to determine the most appropriate way of delivering compliance against the passport. Once complete, which is anticipated to be the end of September, a full time bound action plan will be developed to mitigate this risk to the lowest level reasonably practicable. Plans include exploring:<br>(1) introducing a charge for DNAs<br>(2) Use of external trainers to support the delivery of the course; however, this may not include the 'Falls element' because this is an addition to the Betsi model.<br>(3) Options for collaboration on training venues<br>(4) Developing existing staff with a professional registration to become manual handling trainers and incentivise this by offering a Train the Trainer Qualification. |
| 304 | Internal Audit | Falls Management                                             | 2023 | Limited | High   | Matter Arising 4: Governance (Operation)                  | 4.1b: Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.                           | 4.1b: Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Chris Lynes, Deputy Executive Director of Nursing                                         | Angela Wood, Executive Director of Nursing and Midwifery  | 30/12/2023 | 30/09/2024 | 4 | SOP reviewed by Health Board Inpatient Falls group membership further minor amendment to align to Health Board Quality Management System to ensure the learning is maximised. For final approval by Health Board Inpatient Falls membership September 2024 and for information for HB Patient Safety Group September 2024.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 326 | Internal Audit | Lessons Learnt                                               | 2023 | Limited | High   | Matter Arising 1: Lessons Learnt (Design)                 | 1.3c: Management to review implemented learning to ensure effectiveness.                                                                                                                                                                 | 1.3c: A new, digital repository of learning and cascade system will be developed. <i>NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.</i>                                                                                                                                                                                                                                                                      | Kath Clarke, Head of Quality                                                              | Angela Wood, Executive Director of Nursing and Midwifery  | 31/03/2024 | 31/12/2024 | 3 | Work continues to develop the new Quality Learning Portal. The database structure has been reworked and development continues now on the front facing apps that will allow staff to enter and review learning. The first of three apps, which will allow users to enter learning into the system, is currently being tested. The second app is due to be completed by the end of September, with the final part of the Solution due to be complete now toward the end of November. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB.                                                                                  |
| 327 | Internal Audit | Lessons Learnt                                               | 2023 | Limited | High   | Matter Arising 2: Make it Safe (Plus) (Design)            | 2.1: Management to formally document and communicate the principles and requirements of Make it Safe (Plus) to ensure consistency across the Health Board. Governance, reporting, and escalation requirements to be clearly defined.     | 2.1: A full review of the incident process and procedure has been commenced, which will be co-designed with staff to ensure that the new procedure is fit for purpose and workable for staff undertaking rapid reviews/investigations and learning.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Tracey Radcliffe, Head of Patient Safety                                                  | Angela Wood, Executive Director of Nursing and Midwifery  | 31/03/2024 | 30/09/2024 | 3 | The Integrated Concerns Framework was presented to Board in July 2024 and will go live September 2024.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 350 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024              | 2024 | Limited | Medium | Matter Arising 1: MCA training levels 1 and 2 (Operation) | 1.1a (i): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.           | 1.1a (i): Undertake a review of MCA mandatory training data for Bank, Locum and Honorary staff and identify low compliance areas in each staffing group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Chris Walker, Head of Safeguarding Adults                                                 | Angela Wood, Executive Director of Nursing and Midwifery  | 30/09/2024 |            |   | Data now being collected and shared at Safeguarding Forums. Advised that from September 2024 MCA Training will formulate part of the mandatory training requirements for all Bank, Locum and Honorary staff. To continue to monitor compliance and escalate as required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 351 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024              | 2024 | Limited | Medium | Matter Arising 1: MCA training levels 1 and 2 (Operation) | 1.1a (ii): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.          | 1.1a (ii): Identify staffing groups who have low compliance and provide data monthly to service leads to action.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Chris Walker, Head of Safeguarding Adults                                                 | Angela Wood, Executive Director of Nursing and Midwifery  | 30/09/2024 |            |   | Work ongoing with the team's Data Analyst and MCA/DoLS Manager. Data is currently shared as per the previous update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |



|     |                |                                                 |      |         |        |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                  |                                                          |            |            |   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| 352 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | Medium | Matter Arising 1: MCA training levels 1 and 2 (Operation) | 1.1a (iii): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.                                                                                                                                                                                     | 1.1a (iii): Review current BCUHB training policies and procedures with service leads for Bank, Locum and Honorary staff to ascertain current agreements in place in relation to the completion of MCA training prior to and during employment.                                                                                                                                                                                                                                                                                                                                                       | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2024 |            |   |  | Advised that as of September 2024 all mandatory training for Bank, Locum, and Honorary Staff will include MCA Level 1 and Level 2 (where applicable). Once active, training compliance will be monitored through Safeguarding Forums.                                                                                                                                                                                                                           |
| 353 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | Medium | Matter Arising 1: MCA training levels 1 and 2 (Operation) | 1.1a (iv): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.                                                                                                                                                                                      | 1.1a (iv): Report monthly compliance of MCA training for bank, locum and honorary staff to IHC Safeguarding Forums for oversight and assurance.                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/06/2024 | 30/09/2024 | 1 |  | Revised implementation date agreed due to delay in change of mandatory training requirements for Bank, Locum, and Honorary staff. Informed that MCA Training Level 1 and 2 will be made mandatory in September 2024. Review of all internal documentation is complete. Please note that the service were commended during the audit for the quality and quantity of processes and policies to support staff.                                                    |
| 356 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 2: DoLS authorisations (Design)            | 2.1a (i): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                                                                                                                       | 2.1a (i): Demand and capacity modelling for Best Interest Assessments to be developed by the Safeguarding Business Team to support data driven decisions.                                                                                                                                                                                                                                                                                                                                                                                                                                            | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 31/07/2024 | 03/12/2024 | 1 |  | Action on track as part of the wider data analysis of DoLS and the MCA. Please note an error in the original impementaion date, should read 31/12/2024, now amended.                                                                                                                                                                                                                                                                                            |
| 357 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 2: DoLS authorisations (Design)            | 2.1a (ii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                                                                                                                      | 2.1a (ii): Increase the Supervisory Body's capacity to complete best interest assessments within agreed timescales and legislative compliance by training 5 additional BIA's from Q2 onwards.                                                                                                                                                                                                                                                                                                                                                                                                        | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2025 |            |   |  | Seven applications received from staff across the Health Board. Agreement in principle to allow all seven to complete the BIA course. Awaiting individual staff management approval. Funded via <del>W/G monies</del>                                                                                                                                                                                                                                           |
| 358 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 2: DoLS authorisations (Design)            | 2.1a (iii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                                                                                                                     | 2.1a (iii): Work Based Quality Improvement programme to be developed and implemented within the 3 high referring areas with high QA rejection rates for applications.                                                                                                                                                                                                                                                                                                                                                                                                                                | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2024 |            |   |  | Work ongoing with the team's Data Analyst and MCA/DoLS Manager. Data is currently shared as per the previous update. DoLS Data Dashboard in development (now in testing stage).                                                                                                                                                                                                                                                                                 |
| 359 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 2: DoLS authorisations (Design)            | 2.1a (iv): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                                                                                                                      | 2.1a (iv): Standard Operating Procedure for MCA and BIA service to be reviewed to strengthen visibility of the team within high risk areas. To include structured weekly visits/daily calls by the MCA Team to high referral areas i.e. DGH and Community Hospitals to increase profile of the MCA Team, provide support for staff, feedback regarding application QA rejection themes (date, signatures) etc.                                                                                                                                                                                       | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2024 |            |   |  | Review of SOP's and other MCA/DoLS related materials is underway and on track.                                                                                                                                                                                                                                                                                                                                                                                  |
| 361 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 2: DoLS authorisations (Design)            | 2.1a (vi): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                                                                                                                      | 2.1 (vi): Digitalise MCA and DoLS documentation to ensure that mandatory fields are completed prior to submission and audit standards.                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2025 |            |   |  | At the last National DoLS/MCA meeting (hosted by PHW and WG) it was agreed that further work was needed to support the digitalisation of the DoLS/MCA paperwork. The Health Board are fully engaged and supportive of a digital system.                                                                                                                                                                                                                         |
| 362 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 3: DoLS Documentation (Operational)        | 3.1a (i): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.                          | 3.1a (i): MCA/DoLS Team to review Standing Operating Procedure for DoLS Applications detailing timescales within the process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2024 |            |   |  | As per the DoLS/MCA legislation, timescales for the completion of a DoLS assessment are clearly recorded. Once allocated for assessment the statutory framework is followed. The wider concern remains the volume of applications. This is a National issue recorded by the Welsh and UK Government. With the appointment of the Minister for MCA (and MHA) it is likely that the DoLS process will be reviewed and the implementation of LPS will be explored. |
| 363 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 3: DoLS Documentation (Operational)        | 3.1a (ii): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.                         | 3.1a (ii): MCA/DoLS Team to provide key performance data regarding compliance of applications within timescales to the managing authorities.                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2024 |            |   |  | As per the previous updates. Data is shared monthly with all Health Board services. Each application is scrutinised on receipt by the team with any errors/good practice reported to the managing authority for their attention. The development of the Data Dashboard will give real-time oversight of all applications, trianing, areas of concerns etc. This is on track to be completed.                                                                    |
| 364 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 3: DoLS Documentation (Operational)        | 3.1a (iii): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.                        | 3.1a (iii): Provide the Managing Authority with opportunities to reflect on the quality of documentation through quarterly learning sessions to commence in Q2. As per action 2.1a: Develop a Work Based Quality Improvement Plan based on themes and trends of the data analysis initially focussing on high referral areas to support reduced rejection rates at QA. Within the improvement plan identify measure for reduction in rejection rates and provide bi-monthly updates on progress and areas that require action with agreed escalation in place to managing authority.                 | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2025 |            |   |  | MCA/DoLS Supervision sessions are being piloted in the East. The seconded MCA/DoLS trianing lead is attending respective sites with high referral rates and low/average compliance. The training lead is developing a paper to support this activity.                                                                                                                                                                                                           |
| 365 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) - 2024 | 2024 | Limited | High   | Matter Arising 3: DoLS Documentation (Operational)        | 3.1a (iv): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.                         | 3.1a (iv): The Standing Operating Procedure for the completion of DoLS documentation to include criteria for triggering an escalation process for areas of concern i.e. high % of rejection at QA, low % compliance with agreed time frames.                                                                                                                                                                                                                                                                                                                                                         | Chris Walker, Head of Safeguarding Adults                                                                                        | Angela Wood, Executive Director of Nursing and Midwifery | 31/12/2024 |            |   |  | % compliance within the timeframe to be included as part of the Data Dashboard. This will offer assurance and evidence of compliance with the framework. Data Dashbaord remains on target for completion by the end of Q2.                                                                                                                                                                                                                                      |
| 458 | Internal Audit | Discharge Arrangements                          | 2024 | Limited | High   | Matter Arising 1: Policy, guidance, and training (Design) | 1.1a: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations. | 1.1a: Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements and the former NU01 BCUHB Hospital Discharge Policy which is out of date. The revised draft policy will bepresented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation. | Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer             | 30/09/2024 |            |   |  | Revised draft policy continues to be progressed through HB governance route with other supporting discharge documentation. Consultation on the final draft is reaching conclusion with responses received from Nursing, Therapy, Pharmacy, Medicine. Presentation at RLG at end of July, and discussion to take place at NWASH on 6th September. Criteria led discharge protocol discussed with IHCs and refresh underway.                                      |

|     |                |                        |      |         |        |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                             |                                              |            |            |   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| 459 | Internal Audit | Discharge Arrangements | 2024 | Limited | High   | Matter Arising 1: Policy, guidance, and training (Design) | 1.1b: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations. | 1.1b: Training Needs Analysis will be undertaken across each acute and community hospital.                                                                                                                                                                                                         | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 30/09/2024 |            |   |  | Discussions took place on 3rd September 2024 regarding a national approach to communication, training and education. Cleansing of D2RA data has concluded showing an improved compliance with reporting against the measures. POCD impact assessment to be completed and returned to Delivery Unit by 9th September 2024.                                                                                                                                                                                |
| 460 | Internal Audit | Discharge Arrangements | 2024 | Limited | High   | Matter Arising 1: Policy, guidance, and training (Design) | 1.1c: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations. | 1.1c: Establish training plan, informed by TNA (to include staff across acute, community hospitals and from disciplines, doctors, nursing, AHP as well as students and including agency / bank staff).                                                                                             | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 31/12/2024 |            |   |  | Work progressing nationally to look at a standardized training / education / awareness programme. All HBs have shared their resources during August for national collation and review.                                                                                                                                                                                                                                                                                                                   |
| 461 | Internal Audit | Discharge Arrangements | 2024 | Limited | High   | Matter Arising 2: D2RA performance Measures (Design)      | 2.1a: Management: • Establish formal escalation arrangements to address and support areas of low / non-compliance. • Ensure that all patients without an allocated D2RA pathway are identified and highlighted to the relevant ward managers. Persistent failure to meet mandated requirements to be escalated.                                                                                                      | 2.1a: Develop Comms and engagement plan, informed by TNA to refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, etc.                                                                                                                                               | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 30/06/2024 | 31/03/2025 | 1 |  | This work is progressing well. The D2RA dashboard is available at operational level (updated twice daily), where compliance by individual ward can be reviewed. Overall compliance reports are provided to each IHC monthly. National meetings are well established and learning from other areas is being considered / implemented where relevant. This is one of the priority areas for the additional members of the team                                                                             |
| 462 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2a (i): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                   | 2.2a (i): Implement comms and engagement plan - Q2                                                                                                                                                                                                                                                 | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 30/09/2024 | 31/03/2025 | 1 |  | Improving compliance with recording against all measures. Further work completed with Informatics on cleansing the data. Progressing well. Work continues to raise awareness via the STREAM group meetings                                                                                                                                                                                                                                                                                               |
| 463 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2a (ii): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                  | 2.2a (ii): Implement comms and engagement plan - Q3                                                                                                                                                                                                                                                | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 31/12/2024 |            |   |  | Improving compliance with recording against all measures. Further work completed with Informatics on cleansing the data. Progressing well. Work continues to raise awareness via the STREAM group meetings                                                                                                                                                                                                                                                                                               |
| 464 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2a (iii): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                 | 2.2a (iii): Implement comms and engagement plan - Q4                                                                                                                                                                                                                                               | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 31/03/2025 |            |   |  | Improving compliance with recording against all measures. Further work completed with Informatics on cleansing the data. Progressing well. Work continues to raise awareness via the STREAM group meetings                                                                                                                                                                                                                                                                                               |
| 465 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2b: Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                       | 2.2b: STREAM development group established and a key priority will be to support increasing the compliance of D2RA reporting.                                                                                                                                                                      | Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)                                            | Imran Devji, Interim Chief Operating Officer | 30/09/2024 |            |   |  | Monthly STREAM meetings well established, which is now core. TOR reviewed. Recommend action is closed as this is part of core business.                                                                                                                                                                                                                                                                                                                                                                  |
| 466 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2c: Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                       | 2.2c: Identify areas of good practice and areas of learning / improvement from poor compliance demonstrated through monthly performance reporting.                                                                                                                                                 | Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)                                            | Imran Devji, Interim Chief Operating Officer | 30/06/2024 |            |   |  | D2RA dashboard has been developed and refined. Compliance and reporting against the measures is flagged with each IHC monthly. Attendance at national meetings is excellent. On going compliance is part of business as usual with a well established framework for introducing new measures.                                                                                                                                                                                                            |
| 467 | Internal Audit | Discharge Arrangements | 2024 | Limited | Medium | Matter Arising 2: D2RA performance Measures (Design)      | 2.2d: Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.                                                                                                                       | 2.2d: Produce monthly reports for Central IHC Director on compliance for review and monitoring at IHC UEC meetings and scrutiny at the 6 Goals programme board (second phase of pilot now commenced for next 6 months April to September to test reporting against revised / additional measures). | Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)                                            | Imran Devji, Interim Chief Operating Officer | 30/06/2024 |            |   |  | D2RA dashboard has been developed and refined. Compliance and reporting against the measures is flagged with each IHC monthly. Attendance at national meetings is excellent. On going compliance is part of business as usual with a well established framework for introducing new measures. Target date has been achieved, therefore recommend to close.                                                                                                                                               |
| 468 | Internal Audit | Discharge Arrangements | 2024 | Limited | High   | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1a: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                                                                                                                                                                                       | 3.1a: Stock take of which areas are doing Board rounds twice daily with the aim of developing an improvement plan to support improved compliance.                                                                                                                                                  | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 30/06/2024 | 31/12/2024 | 1 |  | This action is still to be progressed Implementation date extended. This work will be key to implementing Red to Green which is not yet implemented in BCUHB but is part of the Goal 5 programme of work that is to be taken forward imminently - additional resource has now been recruited to (commenced 2nd September 2024) into the 6 Goals programme. Additional resource is also confirmed from the transformation team. Priorities and workplan for the next 4 months will be agreed in September |

|     |                |                        |      |         |      |                                                           |                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                   |                                                                                                                                                                             |                                              |            |            |   |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| 469 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1b: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                                  | 3.1b: Agree robust reporting and governance arrangements at RPB level.                                                                                                                                            | Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning                                                                                            | Imran Devji, Interim Chief Operating Officer | 30/09/2024 |            |   | Reporting schedule agreed with RLG. New reporting requirements now set out by WG, with Regional representation at the Care Action Committee - 7 performance measures agreed. Recommend for closure.                                                                                                                                                                                                                                                           |
| 470 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1c (i): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                              | 3.1c (i): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 1   | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 30/06/2024 | 30/09/2024 | 1 | Completed - Q1                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 471 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1c (ii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                             | 3.1c (ii): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 2  | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 30/09/2024 |            |   | Feedback received from the last submission of the POCs action plan. New targets set by WG and actions agreed to achieve these monitored by monthly meetings with NHS Exec, LAs & HB. Total Delays Ambition: 15% reduction by November (52 Patients across North Wales) Total Days Delayed Ambition: 20% reduction by November Assessment Delays Ambition: 20% reduction by November (32 Patients across North Wales) Maintain position over the winter months |
| 472 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1c (iii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                            | 3.1c (iii): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 3 | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 31/12/2024 |            |   | Feedback received from the last submission of the POCs action plan. New targets set by WG and actions agreed to achieve these monitored by monthly meetings with NHS Exec, LAs & HB. Total Delays Ambition: 15% reduction by November (52 Patients across North Wales) Total Days Delayed Ambition: 20% reduction by November Assessment Delays Ambition: 20% reduction by November (32 Patients across North Wales) Maintain position over the winter months |
| 473 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1c (iv): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                             | 3.1c (iv): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 4  | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 31/03/2025 |            |   | Feedback received from the last submission of the POCs action plan. New targets set by WG and actions agreed to achieve these monitored by monthly meetings with NHS Exec, LAs & HB. Total Delays Ambition: 15% reduction by November (52 Patients across North Wales) Total Days Delayed Ambition: 20% reduction by November Assessment Delays Ambition: 20% reduction by November (32 Patients across North Wales) Maintain position over the winter months |
| 476 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1 (iii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                             | 3.1d (iii): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. <b>QUARTER 3</b>            | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 31/12/2024 |            |   | Q3 Not due but actions as above                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 477 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 3: Pathways of Care Delays (Design)        | 3.1 (iv): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.                                                              | 3.1d (iv): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. <b>QUARTER 4</b>             | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer | 31/03/2025 |            |   | Q4 Not due but actions as above                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 478 | Internal Audit | Discharge Arrangements | 2024 | Limited | High | Matter Arising 4: Adverse discharges / Incidents (Design) | 4.1: Management establish formal overarching policy or Standard Operating Procedure to support the operational management of incidents, including providing for adverse discharges. Governance, reporting, and escalation requirements must be clearly defined. | 4.1: Each IHC to establish an Adverse Discharge Group with clear ToRs.                                                                                                                                            | Libby Ryan-Davies, IHC Director - Central                                                                                                                                   | Imran Devji, Interim Chief Operating Officer | 30/09/2024 |            |   | Well established in the west and have commenced in other IHC. Needs embedding into core business                                                                                                                                                                                                                                                                                                                                                              |

|     |                |                                                              |      |         |        |                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                             |                                                           |             |            |   |                                                                                                                                                                                                                                                                                                        |
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| 479 | Internal Audit | Discharge Arrangements                                       | 2024 | Limited | Medium | Matter Arising 4: Adverse discharges / Incidents (Design)                   | 4.2: Management ensure adverse discharges are reviewed in accordance with stipulated timelines, with action taken (where necessary) and outcomes fed back to partner organisations in a timely manner.                                                                                                                                                                                                                                                                                          | 4.2: Hold Discharge webinars with Care Homes across each IHC to improve communication and build trust between Health and Providers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations) | Imran Devji, Interim Chief Operating Officer              | 30/09/2024  | 31/12/2024 | 1 | This action will be picked up as part of work progressing on unscheduled care, but due to capacity in the teams has not been progressed at the pace desired.                                                                                                                                           |
| 487 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | Medium | Matter Arising 1: Policies & Procedures (Operation)                         | 1.1a: The HS01 Policy, and supporting procedures and documents on BetsiNet require a review to ensure staff are provided with up-to-date requirements and guidance relating to Health & Safety.                                                                                                                                                                                                                                                                                                 | 1.1a: The Policy is in review and will be completed and submitted for approval to the Health Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security                                                                                   | Carol Shillabeer, Chief Executive                         | 31/07/2024  |            |   | Revised interim Policy will go to Executives in Sept 2024                                                                                                                                                                                                                                              |
| 488 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | High   | Matter Arising 1: Policies & Procedures (Operation)                         | 1.1b: Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board                                                                                                                                                                                                                                                                                                                                | 1.1b: The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Carol Shillabeer, Chief Executive                                                                                                                                           | Carol Shillabeer, Chief Executive                         | Immediately |            |   | The Director of Environment post remains unfilled and has gone back out to agency                                                                                                                                                                                                                      |
| 489 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | High   | Matter Arising 2: Monitoring and reporting of Health and Safety (Operation) | 2.1a: Management ensure regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues through the appropriate governance structure, in line with the HS01 policy and terms of reference for relevant meetings (Strategic Occupational Health and Safety Group, Quality Safety and Experience Committee and Risk Management Group).                                                                                                                       | 2.1a: Reporting to QSE recommenced in December 2023, however SOHSG will now report to People and Culture Committee, we are assuming this committee will escalate issues to RMG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security                                                                                   | Carol Shillabeer, Chief Executive                         | 29/02/2024  |            |   | Complete, new reporting structure established                                                                                                                                                                                                                                                          |
| 490 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | High   | Matter Arising 2: Monitoring and reporting of Health and Safety (Operation) | 2.1b: The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE                                                                                                                                                                                               | 2.1b: To ensure that reports are received by the Chair of SOHSG from all relevant areas, TOR to be recirculated to departmental leads, chair of SOHSG needs to be an Executive Director in order to be quorate so will need to be appointed by Executive team. Will be included in SOHSG reports from 2nd Quarter 2024 through People and Culture Committee, responsibility of responsible Executive Director                                                                                                                                                                                                                                                                                                                                                                                                        | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security                                                                                   | Carol Shillabeer, Chief Executive                         | 29/02/2024  |            |   | Meeting held with CEO to revise reporting structure for SOHSG, reports now go by exception to P&CC, IHC's and Divisions now compliant                                                                                                                                                                  |
| 491 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | Medium | Matter Arising 3: Health & Safety Training (Operation)                      | 3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007". | 3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security                                                                                   | Carol Shillabeer, Chief Executive                         | 01/09/2024  |            |   | Unchanged awaiting appointment of Executive team members to approve training programme with CEO                                                                                                                                                                                                        |
| 493 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | High   | Matter Arising 5: Gap analysis (Operation)                                  | 5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board                                                                                                                                                                                                                                    | 5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security                                                                                   | Carol Shillabeer, Chief Executive                         | 30/04/2024  |            |   | Health and Safety Policy and Gap analysis is going to the Board in September                                                                                                                                                                                                                           |
| 494 | Internal Audit | Health and Safety - 2024                                     | 2024 | Limited | Medium | Matter Arising 6: Action Plans (Operation)                                  | 6.1: Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress                                                                                                                                                                                                                                                                                                                                           | 6.1: Estates are ensuring regular internal reviews of H&S for their areas and working on an action plan to ensure that any actions raised are addressed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Arwel Hughes, Head of Operational Estates                                                                                                                                   | Carol Shillabeer, Chief Executive                         | 01/04/2024  | 06/12/2024 | 1 | Health and Safety meeting took place on 14th August 2024 and action plan reviewed. Request that the implementation date is extended to demonstrate the effectiveness of the action plan over a period. Health and Safety meetings are held bi-monthly. Revised implementation date - 6th December 2024 |
| 513 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 1: Process management (Design)                               | 1.1.2: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.                                                                                             | 1.1.2: The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i> | Stephen Powell, Director of Performance and Commissioning                                                                                                                   | Stephen Powell, Director of Performance and Commissioning | 31/08/2023  | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.               |
| 514 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 2: Contractual obligations (Design)                          | 2.1.2: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.                                                                                                                                                                                                                                                        | 2.1.2: The Health Board will ensure all agreements with Providers are backed up by a signed contract. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                                                                                                                                                                                                               | Stephen Powell, Director of Performance and Commissioning                                                                                                                   | Stephen Powell, Director of Performance and Commissioning | 31/08/2023  | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.               |
| 515 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 2: Contractual obligations (Design)                          | 2.1.3: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.                                                                                                                                                                                                                                                        | 2.1.3: The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                                                                                                                                             | Stephen Powell, Director of Performance and Commissioning                                                                                                                   | Stephen Powell, Director of Performance and Commissioning | 31/08/2023  | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.               |
| 516 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 2: Contractual obligations (Design)                          | 2.1.4: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.                                                                                                                                                                                                                                                        | 2.1.4: The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                                                                                                                                                                        | Stephen Powell, Director of Performance and Commissioning                                                                                                                   | Stephen Powell, Director of Performance and Commissioning | 31/08/2023  | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.               |



|     |                |                                                              |      |         |        |                                                                    |                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                           |                                                           |            |            |   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| 517 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 2: Contractual obligations (Design)                 | 2.1.5: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.                                                                                  | 2.1.5: The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                                                                                                   | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 31/08/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                           |
| 518 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 3: Quality measures (Operation)                     | 3.1.2: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.                                                                                                                                                                                                           | 3.1.2: The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i> | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 31/03/2024 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                           |
| 519 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 3: Quality measures (Operation)                     | 3.1.3: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.                                                                                                                                                                                                           | 3.1.3: The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner/CQC. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                            | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 31/07/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                           |
| 520 | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High   | Matter Arising 4: Board assurance (Design)                         | 4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.                                                                                                                                               | 4.1.2: The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation route. <i>Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.</i>                                                                | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 31/08/2023 | 30/09/2024 | 2 | The meeting between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024 was postponed. Another meeting to be arranged.                                                                                                                                                                                                                                                                                                                                                           |
| 552 | Internal Audit | Charitable Funds                                             | 2022 | Limited | Medium | Matter Arising 5: Fundraising (Design)                             | 5.1: A regular review and analysis of fundraising should be undertaken by the team, with results informing fundraising planning.                                                                                                                                                                                          | 5.1: New dedicated data management resource to be in place by end of March 2023 with new reporting for CFC in place by September 2023 to ensure consistent regular review and analysis of fundraising should be undertaken by the team                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Kirsty Thomson, Head of Fundraising : Awyr Las            | Russell Caldicott, Interim Executive Director of Finance  | 30/09/2023 |            |   | The CFC receives regular updates and analysis of the fundraising undertaken. This is via of the Finance Report, which describes the movement in the Legacy and Donation Income. There is also a regular paper providing the by the Charity Support Team, which describes the fundraising undertaken by the fund managers. The Charity Strategy was approved by the CFC in April 2024, this sets out the future strategic direction regards to fundraising plans, including consideration of a Staff Lottery for example. These initiatives will be progressed in line with the Operation Plan which is due to progress to the CFC later this year. |
| 553 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | Medium | Matter Arising 1: Business Continuity Working Group (Operation)    | 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                                                                                                                           | 1.1a: 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.                                                                                                                                                                                                                                                                                                                                                                                                   | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 554 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | Medium | Matter Arising 1: Business Continuity Working Group (Operation)    | 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.                                                                                                                                                                       | 1.1b: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 555 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | Medium | Matter Arising 1: Business Continuity Working Group (Operation)    | 1.1c: The quorum must be clearer as only one meeting in the last two years was quorate.                                                                                                                                                                                                                                   | 1.1c: The Terms of reference will be updated to include the revised number of members required for the meetings to be quorate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 556 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | Medium | Matter Arising 1: Business Continuity Working Group (Operation)    | 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                                                                                                                                                                  | 1.1d: The training provision for the BC leads will be reviewed and scheduled to take place from the end of June                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 13/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 557 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | High   | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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. | 2.1a: 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                                                                                                                                                                                         | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 558 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | High   | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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.                                                                                                                                      | 2.1b: Localities need to be advised to report all tested BC plans to the EPRR Team to include lessons identified and action plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 559 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | High   | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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).                                                                                                                                                         | 2.1c: The Business Continuity Update and Monitoring Reports will include the testing of plans included within the KPIs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 560 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | High   | Matter Arising 3: Escalation of non-completion of BCPs (Operation) | 3.1a: The new Civil Contingencies Assurance Group (CCAG) is formally established and Terms of Reference reflect direct reporting groups.                                                                                                                                                                                  | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 561 | Internal Audit | Business Continuity Plans                                    | 2022 | Limited | High   | Matter Arising 3: Escalation of non-completion of BCPs (Operation) | 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.                                                                                                              | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sharon Scott, EPRR Lead                                   | Jane Moore, Acting Executive Director of Public Health    | 30/06/2022 |            |   | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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| 562 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.1a: 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.                                                                                                  | 2.1a: 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]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Interim Deputy Executive Medical Director/ Phil Meakin, Interim Deputy Board Secretary | Nick Lyons, Executive Medical Director | N/A        |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 563 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.1b: 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.                                                                                                  | 2.1b: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | n/a        |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 564 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.2a: Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.                                                                                                                                                                                                                                     | 2.2a: Management comment There is a need for more clarity from key stakeholders on what is expected from Tier 2 project and what is required from project leads, this would help improve the information when sharing, such as: • providing the required information on the project, for example risks, methodology, the aim of the project • how local stakeholders will progress taking project forward and outline how the audit results are going to drive improvements • clear progress updates provided to the Clinical Effectiveness team on quarterly basis throughout the year, including action planning when complete or a rationale of why a project has not progressed in year as planned Complete 30th September 2022 (sub: to release of operating model) • wider information required from the project lead at point of suggesting topic (or retrospectively for this year), which clearly identifies the rationale for the project, risks, methodology, and aim (refer to attached gap analysis document) The Clinical Effectiveness team have been introducing the new management/tracking software, Audit 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. Agreed Actions 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. | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 30/02/2022 |  |  | AMaT has now been implemented in the Health Board, and is being utilised to capture actions from clinical audits, and provides greater facility to document actions. Suggest this is put forward for closure as this is a historical recommendation. |
| 565 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.2b: Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.                                                                                                                                                                                                                                     | 2.2b: Determine feasibility of augmenting the current document management system (local spreadsheet) as interim measure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 30/04/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 566 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 3.1: Regular quarterly reports are to be presented to the Quality, Safety and Experience Committee, highlighting progress against the plan.                                                                                                                                                                                                                           | 3.1: 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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 31/05/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 567 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 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 | 3.2: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 30/04/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 568 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 3.3: The overarching Clinical Effectiveness Group should receive regular reports from local Clinical Effectiveness Groups as per the Cycle of Business                                                                                                                                                                                                                | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 31/05/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 569 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 4.1a: 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                              | 4.1a: 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 31/10/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 570 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 4.1b: 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                              | 4.1b: Ensure that health check meetings are continued, to secure understanding and engagement / accountability of triumvirates, whilst other changes are in place to ensure consistency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 31/05/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 571 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                                                                     | 4.2: 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 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 30/09/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |
| 572 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                                                | 4.3a: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Joanne Shillingford, Head of Clinical Effectiveness                                    | Nick Lyons, Executive Medical Director | 30/09/2022 |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                 |

|     |                |                                            |      |         |      |                                                                                             |                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                   |                                              |                                                                                |  |  |                                                                      |
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| 573 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                               | 4.3b: 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. | Joanne Shillingford, Head of Clinical Effectiveness; James Risley and Jim McGuigan, Deputy Executive Medical Directors                                            | Nick Lyons, Executive Medical Director       | Contingent with review of Business Case to ensuring clinical capacity included |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 574 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                               | 4.3c: Secure capacity identified within business case (delivering a hub and spoke model to increase capacity within central team aligned to locality.                                                                                                                                                                                                                                                                                                                                                                                                                             | Joanne Shillingford, Head of Clinical Effectiveness; James Risley and Jim McGuigan, Deputy Executive Medical Directors; Matthew Joyes, Deputy Director of Quality | Nick Lyons, Executive Medical Director       | 31/05/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 575 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                               | 4.3d: 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.                                                                                                                                                                                                                                                                                                                                        | Joanne Shillingford, Head of Clinical Effectiveness; James Risley and Jim McGuigan, Deputy Executive Medical Directors; Matthew Joyes, Deputy Director of Quality | Nick Lyons, Executive Medical Director       | 31/05/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 576 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                                                                                               | 4.3d: Ensure continuation of current health check meetings to develop and maintain division visibility of audit activity and risks, and to promote engagement and accountability.                                                                                                                                                                                                                                                                                                                                                                                                 | Joanne Shillingford, Head of Clinical Effectiveness; James Risley and Jim McGuigan, Deputy Executive Medical Directors; Matthew Joyes, Deputy Director of Quality | Nick Lyons, Executive Medical Director       | 31/05/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 577 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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                                                                 | 5.1a: meeting has been held on 6 th 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                                                                                                                                                                                                                          | Senior Development Analyst                                                                                                                                        | Nick Lyons, Executive Medical Director       | 30/06/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 578 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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.                                                                                                  | 5.2: 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                                                                                                                                                                                                                                                                                                                                                             | Joanne Shillingford, Head of Clinical Effectiveness                                                                                                               | Nick Lyons, Executive Medical Director       | 30/04/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 579 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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. | 5.3a: 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                                                                                                                                                                                                                                                                                                                 | Joanne Shillingford, Head of Clinical Effectiveness; Support team                                                                                                 | Nick Lyons, Executive Medical Director       | 31/12/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 580 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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. | 5.3b: 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.                                                                                                                                                            | Joanne Shillingford, Head of Clinical Effectiveness; Support team                                                                                                 | Nick Lyons, Executive Medical Director       | 31/03/2023                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 581 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 1: Governance arrangements (Operation)                                       | 1.1a: Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                                                                                                 | 1.1a (i): Planning has been underway to put a structure in place for West IHC to create 7 Operational Delivery Groups, to mirror what was understood to be the Health Board approach. This work has been paused pending further clarity and an away day to be organised by the Deputy Chief Executive. It is envisaged that the new governance arrangements will be in place to fully commence from the beginning of Q4, 22-23.                                                                                                                                                   | Neil Rogers, IHC Operations Director, West                                                                                                                        | Imran Devji, Interim Chief Operating Officer | 31/12/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 582 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 1: Governance arrangements (Operation)                                       | 1.1a: Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                                                                                                 | 1.1a (ii): Pending the revised governance arrangements for West IHC being approved, pre existing meetings at Ysbyty Gwynedd will be reconvened, including those that were temporarily stood down, to maintain visibility for the IHC Leadership Team across all areas of the business. This will include a review of their purpose /ToR, and whether they should continue as an Acute only meeting, or be retired and merge in to the appropriate IHC Operational Delivery Group                                                                                                  | Neil Rogers, IHC Operations Director, West                                                                                                                        | Imran Devji, Interim Chief Operating Officer | 31/10/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 583 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                                                       | 2.1a: Management to identify and progress savings schemes as a matter of urgency.                                                                                                                                                                                                                                                                    | 2.1a(i): Savings Forum to be established across the newly formed West IHC to include a cross section of operational and clinical teams to establish further proposals for savings schemes to be worked up                                                                                                                                                                                                                                                                                                                                                                         | Neil Rogers, IHC Operations Director, West; Chief Finance Officer                                                                                                 | Imran Devji, Interim Chief Operating Officer | 30/11/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 584 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                                                       | 2.1a: Management to identify and progress savings schemes as a matter of urgency.                                                                                                                                                                                                                                                                    | 2.1a(ii): West IHC Senior Team to focus on shorter term rectification / mitigations to manage the financial gap as a result of the incomplete delivery of savings, and identify any further potential transformational schemes and savings through the synergies of coming together as an integrated service.                                                                                                                                                                                                                                                                     | Neil Rogers, IHC Operations Director, West; Chief Finance Officer                                                                                                 | Imran Devji, Interim Chief Operating Officer | 30/11/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 585 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                                                       | 2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.                                                                                                                                                                                                                                     | 2.1b(i): Pre-existing Finance & Performance meetings (Area and Ysbyty Gwynedd) to be re-established to maintain overview and scrutiny of the position for Q3 22/23.                                                                                                                                                                                                                                                                                                                                                                                                               | Neil Rogers, IHC Operations Director, West                                                                                                                        | Imran Devji, Interim Chief Operating Officer | 31/10/2022                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |
| 586 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                                                       | 2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.                                                                                                                                                                                                                                     | 2.1b(ii): In Line with new Operating Model, IHC F&P Operational Delivery Group to be established when corporate position on desired structure is clarified.                                                                                                                                                                                                                                                                                                                                                                                                                       | Neil Rogers, IHC Operations Director, West                                                                                                                        | Imran Devji, Interim Chief Operating Officer | 31/01/2023                                                                     |  |  | <i>Retrospectively added to tracker, therefore no update to date</i> |



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| 587 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation)                                    | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4.1a(i): The new IHC leadership team is concerned about the volume of overdue complaints and the length of time that some complainants are awaiting a response, and considerable effort has already gone in to reducing the backlog, which is much improved as at early October 2022.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Victoria Peach, IHC Nurse Director, West                                             | Imran Devji, Interim Chief Operating Officer | 30/11/2022 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 588 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation)                                    | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4.1a(ii): System of allocating an Investigating Officer for complaints and incidents to be reviewed, to ensure that staff have appropriate training and support, and allocated time to discharge these responsibilities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Victoria Peach, IHC Nurse Director, West                                             | Imran Devji, Interim Chief Operating Officer | 30/11/2022 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 589 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation)                                    | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4.1a(iii): Oversight of complaints and incidents performance to be formalised via Directorate Accountability meetings on the Ysbyty Gwynedd site                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Neil Rogers, IHC Operations Director, West                                           | Imran Devji, Interim Chief Operating Officer | 31/10/2022 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 590 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation)                                    | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4.1a(iv): Level of manpower that is provided by the Governance team to support the Directorates on the Ysbyty Gwynedd site to be reviewed and benchmarked against the other sites, together with investigation of the analytical tools available to identify recurring themes / common cause in incidents and complaints                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Neil Rogers, IHC Operations Director, West                                           | Imran Devji, Interim Chief Operating Officer | 31/01/2023 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 591 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 5: Risk Management (Operation)                                             | 5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions / dates are included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5.1a: A full review of the Risk Register will be undertaken across the West IHC to resolve the issues identified at Ysbyty Gwynedd, to include appropriate controls and mitigating actions. There has already been progress as reported at the Risk Management Group on 4th October, with 93% of risks "in date"                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Neil Rogers, IHC Operations Director, West; Victoria Peach, IHC Nurse Director, West | Imran Devji, Interim Chief Operating Officer | 30/11/2022 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 592 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 5: Risk Management (Operation)                                             | 5.1b Management to review consistency of reporting in accordance with the revised governance structure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5.1b: A Risk Operational Delivery Group will be established as part of the revised governance structure with appropriate senior oversight and service representation to ensure that there is consistency of reporting across the West IHC, that risks are appropriately scrutinised and scored and visible on the live register, and appropriate escalation to Tier 1 is followed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Neil Rogers, IHC Operations Director, West; Victoria Peach, IHC Nurse Director, West | Imran Devji, Interim Chief Operating Officer | 31/01/2023 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 593 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design) | 6.1a(i) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.                                                                                                                                                                                                                                                                                                                                                                       | 6.1a(i): A cycle of business will be established to ensure that the West IHC maintains oversight that audits are being undertaken across all areas and that the results are being reviewed in the appropriate forum and that any follow up action required is tracked. The Quality Operational Delivery Group, in the revised governance structure, will ensure wider visibility and learning from audit activities across the IHC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Karen Mottart, IHC Medical Director                                                  | Imran Devji, Interim Chief Operating Officer | 31/01/2023 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 594 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited | High | Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design) | 6.1a(ii) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.                                                                                                                                                                                                                                                                                                                                                                      | 6.1a(ii): Directorate Accountability meetings at Ysbyty Gwynedd will be relaunched as part of the revised governance structure, and will provide the ability to scrutinise audit activities and follow through of actions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Neil Rogers, IHC Operations Director, West                                           | Imran Devji, Interim Chief Operating Officer | 31/10/2022 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 595 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital | 2022 | Limited | High | Matter Arising 1: Governance arrangements (Operation)                                     | 1.1a Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                                                                                                                                                                                                                                                                                                                                                       | 1.1a Plans to align the governance structure of the IHC with the corporate structure are being finalised with the Associate Director of Governance. Expected timescale to be agreed is 3-4 weeks. • Health and Safety ToR – Signed off 21.10.22 • Risk Management ToR - Signed off 17.11.22 • Finance and Performance ToR – Signed off 16.11.22 • Quality Delivery Group ToR – Signed off 25.10.22 • Senior Leadership ToR- Draft ToR awaiting structure finalisation • Management Group Meeting ToR - Draft ToR awaiting structure finalisation • New WMH Health and Safety and Risk Management ToR 31 January 2023 EIHC Director of Operations Management additional comments: The Acute Site has changed the original TOR to feed into the EIHC Health and Safety meeting and the EIHC Risk Meeting. These meeting report into F&P, Quality for information and or action and to the Executive Risk Management Group and the Executive SOSH Group. The Management Meeting is a work meeting that reports into the F&P meeting, this meeting is used to discuss and agree short term actions. Minutes will report into F&P SLT – Senior Leadership Team A new SLT is being developed as part of the new EIHC governance arrangements, this will sit above the 3 Operational Delivery Groups; (To note when the new governance arrangements have been confirmed by the Executive Management Senior Team, this EIHC Governance arrangements will change to match, this is a draft working arraignment pending any Executive Changes. ☑ Quality ☑ Finance and Performance ☑ Transformation | Ian Donnelly, IHC Operations Director, East                                          | Imran Devji, Interim Chief Operating Officer | 31/01/2023 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 596 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital | 2022 | Limited | High | Matter Arising 4: Complaints (Operation)                                                  | 4.1a Management to review and action overdue complaints as a priority.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4.1a: • Trajectory for compliance completed, for weekly monitoring (Complete) • AMMP concerns to be added to weekly concern meeting for tracking • Ombudsman cases to be added to weekly concerns meeting for tracking • Consider expanding weekly meeting to include all IHC services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Naomi Holder, Associate Director of Nursing, Integrated Health Community East        | Imran Devji, Interim Chief Operating Officer |            |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                             |
| 602 | Internal Audit | On-Call arrangements                                  | 2022 | Limited | High | Matter Arising 1 – Review of on-call arrangements (Design)                                | 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. | 1.1b: Proposals will be presented to the Executive Team, for approval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Unknown at present                                                                   | Unknown at present                           | 12/10/2022 |  |  |  | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report |
| 603 | Internal Audit | On-Call arrangements                                  | 2022 | Limited | High | Matter Arising 4 – Training (Design)                                                      | 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.                                                                                            | 4.1b: Manual to be developed with key information, and details for those on call.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Unknown at present                                                                   | Unknown at present                           | 24/10/2022 |  |  |  | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report |
| 604 | Internal Audit | On-Call arrangements                                  | 2022 | Limited | High | Matter Arising 4 – Training (Design)                                                      | 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.                                                                                            | 4.1c: All staff to receive training with a programme and timescale set for refresher training every two years.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Unknown at present                                                                   | Unknown at present                           | 12/12/2022 |  |  |  | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report |



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| 605 | Internal Audit | On-Call arrangements  | 2022 | Limited | High   | Matter Arising 4 – Training (Design)                                                                                       | 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.                                                                                                                                                                                                                                                                                                                                                                           | 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. | Unknown at present                           | Unknown at present                | 10/09/2022 |  |  | Discussions ongoing around who is the lead Executive on progressing the recommendations within this audit report |
| 606 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.1: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.1: New SRO for Engagement Domain has been identified – Director of Partnerships, Engagement and Communication                                             | Deputy Chief Executive                       | Deputy Chief Executive            | N/A        |  |  | Retrospectively added to tracker, therefore no update to date                                                    |
| 607 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.2: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.2: Terms of Reference to be reviewed and presented to TIIF Steering Group                                                                                 | Pam Wenger, Director of Corporate Governance | Carol Shillabeer, Chief Executive | 31/03/2022 |  |  | Retrospectively added to tracker, therefore no update to date                                                    |
| 608 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.3: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.3: Reporting arrangements to be incorporated within the ToR Review                                                                                        | Pam Wenger, Director of Corporate Governance | Carol Shillabeer, Chief Executive | 31/03/2022 |  |  | Retrospectively added to tracker, therefore no update to date                                                    |
| 609 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.4: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.4: Minutes of reporting groups will be taken and a CAR provided to the TIIF Steering Group                                                                | Pam Wenger, Director of Corporate Governance | Carol Shillabeer, Chief Executive | 01/01/2022 |  |  | Retrospectively added to tracker, therefore no update to date                                                    |

|      |                |                              |      |         |        |                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      |                                              |                           |            |   |  |                                                                                                                                                                                                      |
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| 610  | Internal Audit | Targeted Intervention        | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.5: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.5: A position on the mapping of the TI actions in line with the Annual Plan will be agreed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Pam Wenger, Director of Corporate Governance                         | Carol Shillabeer, Chief Executive            | 30/04/2022                |            |   |  | Retrospectively added to tracker, therefore no update to date                                                                                                                                        |
| 611  | Internal Audit | Targeted Intervention        | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.6: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.6: Full evidence will remain available to the Evidence and Outcomes Groups                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Pam Wenger, Director of Corporate Governance                         | Carol Shillabeer, Chief Executive            | 01/01/2022                |            |   |  | Retrospectively added to tracker, therefore no update to date                                                                                                                                        |
| 612  | Internal Audit | Targeted Intervention        | 2022 | Limited | Medium | Matter Arising - ISS.2 – Welsh Government Framework requirements (Operating effectiveness)                                   | 2: The Health Board ensure the Framework for the additional financial investment is completed and shared with the Board and Welsh Government.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2: Framework to be shared with Welsh Government.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Russell Caldicott, Interim Executive Director of Finance             | Carol Shillabeer, Chief Executive            | 31/01/2022                |            |   |  | Retrospectively added to tracker, therefore no update to date                                                                                                                                        |
| 613  | Internal Audit | Targeted Intervention        | 2022 | Limited | Medium | Matter Arising - ISS.3 – Targeted Intervention supporting evidence (Operating effectiveness)                                 | 3: The Chair of the Evidence Group requests further evidence from the SRO for Mental Health & CAMHS concerning Attribute M14.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3: Completed and will be presented to the next Evidence Group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Gareth Evans, Acting Executive Director Therapies and Health Science | Carol Shillabeer, Chief Executive            | 31/03/2022                |            |   |  | Retrospectively added to tracker, therefore no update to date                                                                                                                                        |
| 802  | Internal Audit | Quality Improvement Strategy | 2020 | Limited | High   | Quality/Welcome Boards                                                                                                       | Management ensure Quality/Welcome Boards are maintained in accordance with the operational procedure – Hospital and Area Directors of Nursing should routinely ensure they receive assurance that this information is up to date.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | The supporting SOP for the ward welcome boards has been updated with clearer guidance for ward teams. The monitoring of the data displayed at ward level is an integral part of the ward accreditation process currently and will be monitored monthly via the revised Matrons Quality Audit about to be launched, 12 months post implementation of the monthly Ward Accreditation metrics completed by Ward Managers.                                                                                                                                                                                                                                                                                                                                                                                                                                | Matthew Joyes, Deputy Director of Quality                            | Debra Hickman, Secondary Care Nurse Director | 01/04/2020                | 30/09/2020 | 1 |  | Retrospectively added to tracker, therefore no update to date                                                                                                                                        |
| 1269 | Internal Audit | Risk Management - June 2024  | 2024 | Limited | High   | Matter Arising 1: Operational risk registers (Operation)                                                                     | 1.1: Health Board management are reminded of the importance of: • Reviewing risks and ensuring they are up to date, with appropriate actions and timescales. • The need for risk management to be embedded into governance structures through regular risk meetings and assurance to the appropriate leadership team It is recognised that this is likely to improve following Risk Management Training.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1.1: Communication will be sent to all service leads reminding them of their responsibilities relating to maintaining up-to-date risk registers with appropriate actions and timescales. A system of sending automatic reminder to handlers and owners where risks need to be updated will be set up. Target Date: Communication by 30 July 2024; Automated; Monitoring and E mail notification system to be launched in September                                                                                                                                                                                                                                                                                                                                                                                                                    | Nesta Collingridge, Head of Risk Management                          | Pam Wenger, Director of Corporate Governance | 30/07/2024 and 30/09/2024 |            |   |  | Communication has been sent to all risk leads for overdue risks and this will be business as usual. To close this recommendation after the notification system has been set up.                      |
| 1271 | Internal Audit | Risk Management - June 2024  | 2024 | Limited | High   | Matter Arising 2: Corporate Risk Register (Operation)                                                                        | 2.1: Head of Risk Management and Corporate Risk Team to review lines of assurance, controls and future actions of corporate risks.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2.1: All corporate risks to be reviewed and quality assured by corporate risk team                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Nesta Collingridge, Head of Risk Management                          | Pam Wenger, Director of Corporate Governance | 30/08/2024                |            |   |  | First round completed. To be reviewed again at the risk scrutiny panel. The next CRR will be reviewed at ET on the 18 Sept, following this, this version will be sent as evidence to close this rec. |
| 1272 | Internal Audit | Risk Management - June 2024  | 2024 | Limited | High   | Matter Arising 3: Risk Management Group (Operation)                                                                          | 3.1: Consideration should be given to the role of the Risk Management Group and whether alternative arrangements may provide effective and regular scrutiny of operational risk registers, and corporate risks for escalation/de-escalation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3.1: The role and remit of the Risk Management Group will be reviewed, and a paper has been drafted for discussion of 'the role and future of RMG' with proposed options at the June meeting. The proposals also notes the need to increase this meeting to monthly. Options will be further considered by the Executive Team for alternative arrangements to provide more effective, regular scrutiny of operational risks and corporate risks. The new arrangement will be approved by Executive Team and Audit Committee. A new arrangement will be established following approval in Q2. Any agreed changes will be reflected in a revised Risk Management Framework and supporting procedures. A terms of reference will be drafted for this meeting following establishment and review Q3 2024. New meeting to be established in September 2024 | Nesta Collingridge, Head of Risk Management                          | Pam Wenger, Director of Corporate Governance | 30/09/2024                |            |   |  | Risk Scrutiny Panel 09.06.24 (monthly) and Risk Forum (3x year). Draft TOR, agenda and COB to be reviewed in the first meeting. For approval at 21/08/24 Executive team meeting                      |

|      |                |                                                                                             |      |         |        |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                    |                                              |            |            |   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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| 1273 | Internal Audit | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | 2024 | Limited | High   | Matter Arising 1: Policy (Design)                                      | 1.1: Management: <ul style="list-style-type: none"> <li>Update policy to reflect current working practice and systems.</li> <li>Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.</li> </ul>                                                                                                                                                                                                                                                                               | 1.1: <ul style="list-style-type: none"> <li>Review and update Policy to ensure that it is in line with the rest of Wales</li> <li>Review Policy to ensure that the pay bands are consistent with the rest of Wales</li> <li>Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.</li> </ul>                                                                                                                                                                       | Philippa Peake-Jones, Head of Corporate Affairs                    | Pam Wenger, Director of Corporate Governance | 31/07/2024 | 31/10/2024 | 2 | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. <ul style="list-style-type: none"> <li>Review and update Policy to ensure that it is in line with the rest of Wales - Work ongoing – document being drafted in line with other Health Boards - REVISED IMPLEMENTATION DATE 31/10/2024</li> <li>Review Policy to ensure that the pay bands are consistent with the rest of Wales - work ongoing - this will be included in the above policy and will be in line with the rest of Wales - REVISED IMPLEMENTATION DATE 31/10/2024</li> <li>Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms - Complete - this has been agreed by the Director of People</li> </ul> |
| 1274 | Internal Audit | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | 2024 | Limited | Medium | Matter Arising 1: Policy (Design)                                      | 1.2: Management: <ul style="list-style-type: none"> <li>Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).</li> </ul>                                                                                                                                                                                                                                                                                               | 1.2: <ul style="list-style-type: none"> <li>Communication briefing to all managers on responsibilities in relation to Declarations of Interest</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                 | Philippa Peake-Jones, Head of Corporate Affairs                    | Pam Wenger, Director of Corporate Governance | 30/09/2024 |            |   | Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. This recommendation is not yet due.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1281 | Internal Audit | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | 2024 | Limited | High   | Matter Arising 5: BCU staff declarations of interest (Operation)       | 5.1: Management: <ul style="list-style-type: none"> <li>Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality).</li> <li>Ensure staff understand when, and how often, a declaration should be made.</li> <li>Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers).</li> <li>Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).</li> </ul> | 5.1: <ul style="list-style-type: none"> <li>Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities.</li> <li>Work with the Workforce Directorate on options around including Declarations on PADR templates</li> <li>Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)</li> </ul>                                                                                                    | Philippa Peake-Jones, Head of Corporate Affairs                    | Pam Wenger, Director of Corporate Governance | 30/09/2024 | 31/10/2024 | 1 | <ul style="list-style-type: none"> <li>Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities - update - The new policy will include the flow charts as an appendices and a communications plan will be drafted once the policy is finalised.</li> <li>Work with the Workforce Directorate on options around including Declarations on PADR templates - update - This is ongoing, it has been agreed by the Deputy Director of People that they can be amended.</li> <li>Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers) - update - These are reviewed on a weekly basis and are being followed up</li> </ul>                                  |
| 1282 | Internal Audit | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | 2024 | Limited | High   | Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation) | 6.1: Management: <ul style="list-style-type: none"> <li>Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated.</li> <li>All hospitality and sponsored events to be approved by a Director / Assistant Director.</li> <li>Ensure all declarations pending approval are reviewed and approved / declined.</li> <li>Ensure provider details are recorded to enable effective monitoring per policy requirements.</li> </ul>                                     | 6.1: <ul style="list-style-type: none"> <li>Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity.</li> <li>Produce a communications plan to raise awareness and compliance</li> </ul>                                                                                                                                                                                                                                                                                                          | Philippa Peake-Jones, Head of Corporate Affairs                    | Pam Wenger, Director of Corporate Governance | 31/10/2024 |            |   | <ul style="list-style-type: none"> <li>Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity - update - The new policy will include the flow charts as an appendices</li> <li>Produce a communications plan to raise awareness and compliance - update - The new policy will include the flow charts as an appendices and a communications plan will be drafted once the policy is finalised</li> </ul>                                                                                                                                                                                                                                                                                                                                                     |
| 1283 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 1: Governance arrangements (Operation)                  | 1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum                                                                                                                                                                                                                                                                                                                                                               | 1.1: Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (ToR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process.                                                                                                                                                                                                                                                                                                                            | Gareth Evans, IHC Director - Central                               | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | A communications plan will be drafted once the policy is finalised                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 1284 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 2: Financial control assurance (Operation)              | 2.1: The IHC Director ensures the Financial Control Group complies with its Terms of Reference and actively supports the IHC in delivering its expenditure reduction to meet its allocated resource.                                                                                                                                                                                                                                                                                                                                                                                         | 2.1: Financial Recovery Plan meetings have been re-established and the ToR will be developed to reflect the reporting arrangements to Performance, Finance and Information Governance (PFIG). The purpose of these groups will be to oversee the planning and delivery of financial targets whilst understanding the impacts of the necessary change to deliver a reduction in financial spend. The implementation of the Financial Recovery framework for the IHC including regular meetings supported by the ToR, will be in place by end of July 2024. | Gareth Evans, IHC Director - Central                               | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | Due to commence end of July                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1285 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 3: Clinical Audit (Operation)                           | 3.1: IHC to ensure that all audits at Tier 1, 2 and 3 are undertaken, and all outstanding responses are received. Findings and lessons learnt must be shared across the IHC and Health Board.                                                                                                                                                                                                                                                                                                                                                                                                | 3.1: The Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance will be overseen by QODG.                                                                                                                                                                                                                                                                                                                                                                      | Tania Bugelli, Consultant Psychiatrist in Liaison and Chair of CEG | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 1286 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 3: Clinical Audit (Operation)                           | 3.2: IHC Clinical Effectiveness Group (CEG) and Quality Operational Delivery Group (QODG) meetings are aligned appropriately so that CEG meets prior to the QODG to enable the reporting of assurance/matters for escalation in a timely manner.                                                                                                                                                                                                                                                                                                                                             | 3.2: The TOR will be reviewed to ensure that this is reflected.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Tania Bugelli, Consultant Psychiatrist in Liaison and Chair of CEG | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 1287 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 4: Concerns, Complaints, Incidents (Operation)          | 4.1: The IHC Director: <ul style="list-style-type: none"> <li>Ensures the IHC responds to all complaints according to expected reporting timelines and all learning is shared across the IHC.</li> <li>Ensures operational management review all open incidents</li> </ul>                                                                                                                                                                                                                                                                                                                   | 4.1: The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines. The QODG will receive assurance through the Patient, Safety Group (PSG). All Services will review their respective open incidents and performance will be monitored at PSG and assurance provided to QODG                                                                                                                                                              | Rachel Bowen, Associate Director of Nursing                        | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 1288 | Internal Audit | Effective Governance – Integrated Health Community (IHC) Central                            | 2024 | Limited | High   | Matter Arising 5: Risk Management (Operation)                          | 5.1: The IHC Director: <ul style="list-style-type: none"> <li>Ensures regular member attendance at the Health &amp; Safety and Risk Management Group in order that they and the Senior Management Team receive assurance concerning the review and progression of all risks.</li> <li>Ensures that all services regularly review their risks in accordance with RMO2 Risk Management Procedures - 6.1 registers.</li> </ul>                                                                                                                                                                  | 5.1: All services will regularly review their service risks in accordance with RMO2 Risk Management Procedures – 6.1 registers. Assurance will be received at the CIHC Health & Safety Risk Management Group. A review of the terms of reference will be undertaken in July 2024 to support regular member attendance.                                                                                                                                                                                                                                    | Gareth Evans, IHC Director - Central                               | Imran Devji, Interim Chief Operating Officer | 31/07/2024 |            |   | TORs were reviewed at 25 July 2024 meeting and members were asked to give feedback for next meeting - ongoing process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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| 1306 | Internal Audit | Budgetary Control                           | 2024 | Limited | Medium | Matter Arising 5: Virement Procedure (Operation)     | 5.1a The Virement procedure is reviewed and updated as necessary ensuring the requirements stipulated in the Standing Financial Instructions are embedded throughout. The procedure should then be published on the Finance Policy/Procedure intranet site for all Budget Holders/Managers to comply with. | 5.1a The Finance teams currently operate a budget virement, management agreeing to an action to review the existing local finance procedure and will look to incorporate the existing procedure (with any amendments following review) within the Budget Manager Handbook.                                                                                                                              | Michelle Jones, Head of Financial Reporting | Russell Caldicott, Interim Executive Director of Finance                     | 30/09/2024 |  |  |  | The current SOP, which is very much a internal Financed department document, on virements has had some updates. Following additional discussion last week this will have additional points added to it regarding costing methodology for WTE changes. Key elements which relate to budget holders responsibilities will be incorporated into budget holders handbook. Due to volume of workload this has not progressed in the timeframe required, however, it is hoped that this can be reported as complete in time for the 24/10/24 update. |
| 1324 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | Medium | Matter Arising 3: Project Execution Plan (Operation) | 3.1: The PEP should be reviewed and updated to reflect this project.                                                                                                                                                                                                                                       | 3.1: Agreed - the PEP is to be updated to reflect current project status and the governance refresh agreed following Gateway review.                                                                                                                                                                                                                                                                    | Daniel Eyre, Head of Capital Development    | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/08/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1327 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | High   | Matter Arising 4: Works Procurement (Operation)      | 4.3: Retrospective approval should be obtained to appoint the preferred contractor for the main works project.                                                                                                                                                                                             | 4.3: Agreed – Discussions to take place with DoF/Deputy DoF to discuss most appropriate approval route.                                                                                                                                                                                                                                                                                                 | Daniel Eyre, Head of Capital Development    | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/08/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1328 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | High   | Matter Arising 4: Works Procurement (Operation)      | 4.4: The UHB should ensure that changes of works packages post tender are appropriately reported and approved.                                                                                                                                                                                             | 4.4: Agreed - Changes to works packages are approved in line with the health board’s capital procedures manual and the change control process noted within the PEP. Going forward full cost report will be issued to the project board for information / approval. Cost report No 6 included in September Project Board Meeting. Any significant variations are highlighted within PM highlight report. | Ruth Stiles, Senior Project Manager         | Chris Stockport, Executive Director of Transformation and Strategic Planning | 30/09/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1331 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | High   | Matter Arising 5: Project Bank Account (Operation)   | 5.1: Formal Welsh Government approval is required to avoid using the Project Bank Account at both the enabling and main works contracts.                                                                                                                                                                   | 5.1: Agreed - The contractor is willing to set up a project bank account, we are currently exploring the process and timescale. Contractor have been instructed to progress.                                                                                                                                                                                                                            | Daniel Eyre, Head of Capital Development    | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/12/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1337 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | Low    | Matter Arising 8: Design sign off (Operation)        | 8.1: Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.                                                                                                                                                    | 8.1: Agreed - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward.                                                                                                                                                                             | Ruth Stiles, Senior Project Manager         | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/08/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1338 | Internal Audit | Orthopaedic Surgical Hub Llandudno Hospital | 2024 | Limited | Low    | Matter Arising 9: Planning Conditions (Operation)    | 9.1: The condition tracker maintained by the UHBs design team should be shared and discussed at Project Board Meetings.                                                                                                                                                                                    | 9.1: Agreed - condition tracker to be requested from Architect and submitted as appendices to highlight report.                                                                                                                                                                                                                                                                                         | Ruth Stiles, Senior Project Manager         | Chris Stockport, Executive Director of Transformation and Strategic Planning | 30/08/2024 |  |  |  | <i>Retrospectively added to tracker, therefore no update to date</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

TEAMMATE UPDATE PRE-2022

APPENDIX 4 - ALL INTERNAL AUDIT PRE-2022 OPEN RECOMMENDATIONS - CATEGORISED AS EITHER 'CLOSED' OR 'IMPLEMENTED - AUDIT APPROVED' ON TEAMMATE

Sorted by TeamMate category

| ID   | Internal Audit/ Audit Office | Report Title                                                              | Year    | Assurance Level | Priority | Recommendation Title                                                                                 | Recommendation                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Original implementation date | Revised implementation date | Number of Revisions | Actual Implementation Date | TeamMate state                | TeamMate system update                                                                                                                                                                                                                                                                                       |
|------|------------------------------|---------------------------------------------------------------------------|---------|-----------------|----------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|---------------------|----------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 735  | Internal Audit               | Staffing costs – Review of staff earning more than £200,000               | 2018/19 | N/A             | High     | Cover colleague pay element                                                                          | The Health Board implements effective management control over the internal locum expenditure and includes all internal locum/ad-hoc engagement within the MASDA approval process                                                                                                                                                                                                                                                                                                 | Investigation will be undertaken to ascertain whether MASDA can be utilised for internal locum payments.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 30/09/2018                   |                             | 0                   | 31/10/2018                 | Closed - Mgt Accepts Risk     | Response given that current system is unable to monitor internal locums.                                                                                                                                                                                                                                     |
| 1115 | Internal Audit               | Ysbyty Gwynedd A&E                                                        | 2017/18 | N/A             | Medium   | Contract Documentation                                                                               | Contracts should not proceed on site until formal contract documentation is completed (signed as a deed by both parties), in accordance with the UHB's Capital Project Manual. Systems and processes should be reviewed to ensure that incomplete contract documentation is appropriately reported to the Board (or nominated committee/ sub-committee).                                                                                                                         | Agreed with Assistant Director of Strategy Capital in email dated 21st August 2018                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28/09/2018                   |                             |                     | 22/11/2018                 | Closed - No Longer Applicable | The capital procedural manual requires that in the event that contracts are not signed prior to the pre-contract site meeting, the Project Manager will set out the timescale for completion of the contract documentation. The Project Board will monitor progress in accordance with the agreed timescale. |
| 1117 | Internal Audit               | Ysbyty Gwynedd A&E                                                        | 2017/18 | N/A             | Low      | Cost Control (Equipment Budget)                                                                      | The project's equipment lists will be reviewed and updated to reflect current requirements and affirm the reported anticipated outturn costs.                                                                                                                                                                                                                                                                                                                                    | Actions to be implemented by Project Director as confirmed by Assistant Director of Strategy Capital in email dated 21st August 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28/09/2018                   |                             | 0                   | 04/03/2019                 | Closed - No Longer Applicable | The equipment list has now been finalised, including clarification of monitors, and costed.                                                                                                                                                                                                                  |
| 1119 | Internal Audit               | Ysbyty Gwynedd A&E                                                        | 2017/18 | N/A             | Medium   | Cost Control (Compensation Events)                                                                   | Project changes will be managed in accordance with contractually stipulated time frames (O). Adviser performance relating to appropriately responding to CEs within contractual time-frames will be recorded via their Key Performance Indicators (O).                                                                                                                                                                                                                           | Actions to be implemented by Project Director as confirmed by Assistant Director of Strategy Capital in email dated 21st August 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28/09/2018                   |                             |                     | 25/02/2019                 | Closed - No Longer Applicable | See updated comments.                                                                                                                                                                                                                                                                                        |
| 675  | Internal Audit               | Welsh Risk Pool - Claims Management Standard                              | 2018/19 | N/A             | Medium   | Duplicate payment                                                                                    | The Health Board should seek reimbursement for the duplicate payment and make the necessary arrangements with the Welsh Risk Pool Whilst we acknowledge that the controls in place have changed significantly since 2014, we would urge Claim Managers to remain vigilant when requesting / processing payments to ensure that each payment is justified and fully supported with relevant backing documentation. Furthermore all key backing documentation should be retained . | In terms of the duplicate payment reimbursement has been requested from WRP for this. As stated in the report, there have been significant changes in the controls in place within the Claims Team since 2014 and there is now a greater use of Datix with prompts to record the current stage and last action taken on the case. Practice has also improved in terms of retaining all documents on Datix ensuring that all finance requests and backing documentation are scanned and saved onto the system together. Furthermore, we have recently reviewed all tem plates and current stages on Datix to ensure we can provide more accurate information for reports. A Claims Working Instruction/SOP, outlining the steps to be taken throughout a claim which details the process when requesting payments from finance is being developed in the West and will be rolled out across BCUHB to ensure practices are the same.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/07/2019                   | 01/10/2019                  | 3                   | 02/10/2019                 | Closed - Not Verified         | Claims Team SOP has been implemented for both Clinical Negligence and Personal Injury Claims                                                                                                                                                                                                                 |
| 676  | Internal Audit               | Risk Management Strategy                                                  | 2018/19 | N/A             | High     | Implementation of Risk Manangement Strategy                                                          | The Accountable Officer, through the Board Secretary and Executive Directors ensure current governance arrangements are robust and all divisions/areas/functions are held to account and provide assurance of full compliance with the Risk Management Strategy and actively manage that risk in accordance with the Health Board's defined risk appetite.                                                                                                                       | To establish a risk forum of senior leaders which will report to the Executive Management Group. This forum will be responsible for reviewing and advising on assurance for risk management compliance and reporting arrangements. · Draft Terms of Reference to be developed · Forum to be considered as part of wider operational governance reporting arrangements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01/03/2019                   |                             | 0                   | 17/01/2019                 | Closed - Not Verified         | Terms of reference drafted and RM Group considered with inaugural meeting to be held on 01/04/2019. See all evidence submitted as part of update status                                                                                                                                                      |
| 677  | Internal Audit               | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A             | High     | Executive responsibilities and update of Escalation policy and Schemes of Reservation and Delegation | The NSL and Escalation Plan and Schemes of Reservation and Delegation should be updated to reflect current responsibilities and consideration given to the appropriateness of the transfer of responsibilities to the Director of Secondary Care, in line with the requirements of the Act.                                                                                                                                                                                      | The NSL and Escalation Plan: Acute Services Policy is due for review in May 2019. The newly appointed Nurse Director for Secondary Care has recently reviewed the policy and had opportunity to comment. The Deputy Director of Nursing and Associate Director of Nursing have also recently reviewed and changes to the policy will include core policy for Act requirements revised responsibilities to reflect Executive portfolios localisation of policy to BCU clarity on SafeCare requirements as wider implementation across BCUHB adult acute medical and surgical section initially with other speciality specific sections e.g. MHLd and Paediatrics as they are included within the Act. The Nurse Staffing Levels Act has been added to the latest version of the Schemes of Reservation and Delegation (SORD) Extract from updated SORD: DELEGATED MATTER DELEGATED TO OPERATIONAL RESPONSIBILITY 53.Nurse Staffing Levels Act (Wales) 2016 Chief ExecutiveExecutive Director of Nursing & Midwifery. The Board Secretary has approved the inclusion and it will be confirmed at the May Audit Committee, after which the SORD will be circulated again with an extra column for Divisions inclusion of the next person in the hierarchy with responsibility for NSL Act requirements. Inclusion of Act responsibilities will be reviewed, including transfer of responsibilities to the Executive Director of Nursing | 10/09/2019                   | 22/04/2020                  | 5                   | 06/04/2020                 | Closed - Not Verified         | Nurse staffing policy approved at QSE                                                                                                                                                                                                                                                                        |
| 678  | Internal Audit               | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A             | High     | Nurse Staffing Levels and Escalation Plan and Recording of breaches on Safecare                      | The NSL and escalation Plan should be reviewed to provide clear instruction on what constitutes a marginal and major breach of the NSL and any associated harms and should clearly state which system(s) should be used to record breaches.                                                                                                                                                                                                                                      | The Nurse Staffing Levels (Wales) Act 2016, and the All Wales Operational Guidance (2018) (and updated draft Feb 2019) (attached), do not reference a major or marginal breach. The Act sections 13 – 17 outlines the steps Health Boards must take, the systems and reporting requirements when the number of nurses deployed varies from the planned roster. The NSL and escalation Plan will therefore be updated in line with the proposed revised all Wales guidance, with local agreement, approved by the Executive Director of Nursing and Midwifery as to the reporting of non-compliance across Secondary Care as outlined on page 22 and 23 of the guidance. Variation from the planned roster must be entered into Safe Care and on Datix and the NSL policy will be updated to articulate this, with required communication to staff. The E Roster team have confirmed there is the option to add notes to the current SafeCare system, which can be used to record the Datix number so the red flag system and Datix correlate. The All Wales Nurse Staffing group have approved the recommendations within the report (attached) which outlines changes to the complaints and incident management processes                                                                                                                                                                                                           | 10/09/2019                   |                             | 0                   | 30/09/2019                 | Closed - Not Verified         | The HB's Policy - Nurse staffing levels has been amended and these definitions have been removed.                                                                                                                                                                                                            |
| 679  | Internal Audit               | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A             | Low      | Reporting to the Board and QSE                                                                       | Whilst Nurse Staffing Level monthly Board reporting is not required under legislation, consideration should be given to separately reporting the Nurse Staffing levels on Act wards within the Safe Staffing report in line with the requirements of the Health Board Action Plan. This could be achieved by using Safecare and e-ectoring data                                                                                                                                  | Secondary Care Nurse Directors are currently reviewing reporting for the Act for the Secondary care Nurse Director. This will include separately reporting the Act within the monthly Integrated Quality and Safety report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10/09/2019                   |                             | 0                   | 23/09/2019                 | Closed - Not Verified         | Reporting cycle deveised at site level, with quarterly report to SCQG and Biannual report to QSE. MAs terclasses revisted and safe care training delivered. monitoring of safecare usage                                                                                                                     |
| 680  | Internal Audit               | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A             | Medium   | Quarterly reporting of Harms and Breaches of the Nurse Staffing Levels                               | There should be complete, clear and consistent reporting of the impact of Nurse Staffing levels and associated harms across the Health Board.                                                                                                                                                                                                                                                                                                                                    | Secondary Care Nurse Directors are currently reviewing reporting for the Act. This will include the agreed reporting format across the three secondary care sites that is complete, clear and consistently reports of the impact of Nurse Staffing levels and associated harms across the Health Board. There are several reports available from the E Roster system and Allocate (the system suppliers) are developing further reports based on Secondary Care feedback that will be available in later versions of the system. There is no confirmed launch date by Allocate for the upgraded system (10.8.3) which can only be supported on the most recent internet browser platforms. The browser systems are not currently available across BCU due to other system capabilities however IT are working on this over the next few months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10/09/2019                   |                             | 0                   | 17/09/2019                 | Closed - Not Verified         | national template implemeneted April 2019, this has been standardised for reporting on site monthly to the Site DoN, quaterly to SCQG and biannually to QSE. First report submitted to Board May 2019.                                                                                                       |



|     |                |                                                                           |         |     |        |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |            |   |            |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| 681 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Safecare Training and Operational guidance for Nurse staffing levels | All Ward staff to be fully trained to use Safecare in line with the requirements of Operational Guidance.                                                                                                                                                                                                                                                                                                                     | Safe care was in the process of being implemented in Wrexham at the time of the audit, which included training of staff. Overall training compliance for Wrexham is 77%, including Evington 63% and Fleming is 82%. In Evington of the 3 staff not trained two work predominately nights and 1 has been off long term sick. Two staff outstanding in Fleming of which one is predominately nights and the other on maternity leave. Where the E Rostering team have been unable to cascade the training to staff, wards have been able to do this. The E Roster team will continue to provide training in the use of Safe Care. The Heads of Nursing will undertake a spot check audit of staff understanding and application in practice on a day to day basis of the Safe Care system. This will be monitored through secondary care accountability meetings                                                                                                                                                                     | 10/09/2019 |            | 0 | 17/09/2019 | Closed - Not Verified | training has been provided on all 3 site, further cascade training has also been implemented. there will be the provision of training for new starters or where a refresher is required, no further large scale training events planned.                                                                                                                                                                                                                                                                                                                                                                                         |
| 682 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Nurse staffing levels and shift times                                | Wards comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act.                                                                                                                                                                                                                                                                                                      | The E Rostering team have been working with Secondary Care Nurse Directors to ensure the E Roster templates comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act. All templates have now been updated in the system to reflect the staffing numbers agreed by the Board in October 2018. There remain discrepancies with the shift times actually worked by the wards versus the hours they are budgeted for which are being addressed by the Nurse Roster Optimisation project. As this is a Health Board wide project, formal consultation on the proposals is necessary, which will occur end March 2019. Subject to the necessary executive approvals, the planned changes, would come into effect on the 4 <sup>th</sup> August Roster due to the 6 week in advance shift approval requirements and the time required for the E Roster team to make the changes in the system. The revised NSL policy will include a section on agreeing and changing templates. | 10/09/2019 |            | 0 | 17/09/2019 | Closed - Not Verified | mitigations in place: SC and Sites has staffing cited on their Risk Registers Adult Staffing policy in place (although under review) Daily harm reviews 3 times daily staffing reviews utilising safe care annual establishment reviews establishment reviews in line with service change harm reports                                                                                                                                                                                                                                                                                                                           |
| 683 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Populating Safecare and Datix Incident reporting                     | Management ensure Safecare is used in accordance with guidance and red flag events and harms are recorded appropriately.                                                                                                                                                                                                                                                                                                      | Secondary Care Site nurse directors will ensure all staff aware of the requirements to ensure SafeCare is used in accordance with guidance. This will be via Heads of Nursing, Matron, Ward Manager meetings and daily staffing huddle. The Guidance for SafeCare will be re-circulated and reinforced by E Rostering team in training events, that red flag events and harms are recorded appropriately. The E Roster team continue to provide training for new staff and wards are able to cascade the training to staff that the E Rostering team have been unable to directly provide this too. User guides are also available on the E Roster website.                                                                                                                                                                                                                                                                                                                                                                        | 10/09/2019 |            | 0 | 30/09/2019 | Closed - Not Verified | safecare training has been completed, all sites monitored as to the use of safecare addressed via bed meetings and roster scrutiny meetings. monthly reports to SCQSG regards staffing related harms.                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 684 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | Medium | Funding and Staffing Strategy                                        | Management to review escalation bed management to ensure compliance with the Health Board policies and operational requirements                                                                                                                                                                                                                                                                                               | Secondary Care Hospital Directors in conjunction with Secondary Care Site Nurse Directors to review their bed escalation policies to ensure core bed base and escalated bed base staffing to meet Act requirements are included.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10/09/2019 | 28/11/2019 | 4 | 28/11/2019 | Closed - Not Verified | Secondary Care Hospital Directors in conjunction with Secondary Care Site Nurse Directors have reviewed their bed escalation policies to ensure core bed base and escalated bed base staffing meets the requirements of the Act.                                                                                                                                                                                                                                                                                                                                                                                                 |
| 685 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | High   | Compliance with governing documents                                  | The Director of Mental Health & LDS, through the management team: Ensure Tier 1 and Tier 2 ToR are reviewed for completeness, accuracy and can be achieved. Servicing of meetings to ensure compliance with expected governance standards including establishing cycles of business; minute taking; submission of papers is subject to review. Liaise with the Office of the Board Secretary for ad-hoc support and guidance. | The Division will ensure that Tier 1 and Tier 2 ToR are reviewed for completeness. Issues of housekeeping and compliance will be addressed to ensure that the Division meets expected governance standards. In addition, MHLD will strengthen links with the Office of the Board Secretary.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 30/04/2019 | 31/05/2019 | 1 | 13/06/2019 | Closed - Not Verified | This review has been implemented and is now agreed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 686 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | High   | Role accountable for governance arrangements                         | The Director of Mental Health & LDS reviews and considers the merits of establishing a senior role, with relevant authority, to ensure governance arrangements are complied with across the Division.                                                                                                                                                                                                                         | The Director of MHLD will review how support to Lead Directors will be facilitated to ensure compliance with Governance arrangements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/04/2019 | 31/05/2019 | 1 | 13/06/2019 | Closed - Not Verified | This senior role has been approved through vacancy control. A job description has been developed and is now working through job matching then recruitment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 687 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | Low    | Divisional Directors                                                 | The Director of Mental Health & LDS reviews both ToR, and considers amalgamating the Divisional Directors meetings into one monthly management team meeting, ensuring its purpose is refreshed and captures existing responsibilities.                                                                                                                                                                                        | The ToR for the Divisional Directors Strategy and Business meetings will be reviewed to ensure they accurately reflect the business of each meeting and a schedule of meetings, together with cycles of business will be agreed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/04/2019 | 31/05/2019 | 1 | 13/06/2019 | Closed - Not Verified | A review has taken place and it has been agreed that the business and strategy meetings will remain separate. For Tier 2 meetings, the QSEEL will remain, Operational Accountability will become finance and performance and strategy will remain. However, the meetings will be held subsequent to each other on the same day. A review of Tier 3 meetings has happened and these meetings have been rationalised with some responsibilities being transferred to localities.                                                                                                                                                   |
| 688 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | Medium | Transformation                                                       | The Director of Mental Health & LDS reviews how assurance and scrutiny of the transformation agenda is taken forward through its governance structure.                                                                                                                                                                                                                                                                        | The ToR for the Divisional Directors Strategy and Business meetings will be reviewed to ensure they accurately reflect the business of each meeting. This will include the transformation agenda, to ensure focus, scrutiny and traction.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30/04/2019 | 31/05/2019 | 1 | 13/06/2019 | Closed - Not Verified | It has been agreed by Divisional Directors that the transformation agenda is now managed through the SSRD and the ToRs will be reflective of this change.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 689 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | Medium | Quality and safety – Governance structure                            | The Director of Mental Health & LDS reviews the quality and safety assurance structure.                                                                                                                                                                                                                                                                                                                                       | The QSEEL agenda has been reviewed, together with the business of the sub-groups that report to it. A revised cycle of business is now in place, together with template documents in support, ie front sheet and Chair's assurance report. The revised cycle of business has now been implemented. In addition, the Director of Nursing MHLD has written to all chairs of the sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. Papers for QSEEL meetings are distributed to members, in accordance with the cycle of business, 7 days prior to the meeting.                                                                                                                                                                                                                                                                                                                                                                                                   | 17/04/2019 |            | 0 | 13/03/2019 | Closed - Not Verified | The QSEEL agenda has been reviewed, together with the business of the sub-groups that report to it. A revised cycle of business is now in place, together with template documents in support, ie front sheet and Chair's assurance report. The revised cycle of business has now been implemented. In addition, the Director of Nursing MHLD has written to all chairs of the sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. Papers for QSEEL meetings are distributed to members, in accordance with the cycle of business, 7 days prior to the meeting. |
| 690 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | Medium | Quality and safety – HARMS Dashboard                                 | The Director of Mental Health & LDS ensures all QSEEL meeting Chairs comply with the instruction from the Director of Nursing that HARMS dashboard forms part of their monthly cycle of business.                                                                                                                                                                                                                             | The Director of Nursing MHLD has written to all chairs of the governance sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. As part of this process, a template report has been developed for locality QSEEL meetings which identifies HARMS dashboard as a specific reportable item. In addition, the HARMS dashboard is discussed daily at each Acute Care meeting, with a summary discussed at the weekly TWC meetings, reported weekly to Divisional TWC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 17/04/2019 |            | 0 | 13/03/2019 | Closed - Not Verified | The Director of Nursing MHLD has written to all chairs of the governance sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. As part of this process, a template report has been developed for locality QSEEL meetings which identifies HARMS dashboard as a specific reportable item. In addition, the HARMS dashboard is discussed daily at each Acute Care meeting, with a summary discussed at the weekly TWC meetings, reported weekly to Divisional TWC.                                                                                                 |
| 691 | Internal Audit | Mental Health and Learning Disabilities Governance Arrangements           | 2018/19 | N/A | Medium | Performance                                                          | The Director of Operations and Service Delivery considers the suite of performance measures for formal reporting and scrutiny and whether the IQPR set of measures should be subject to formal monthly review.                                                                                                                                                                                                                | Divisional Performance Reports continue to be hosted on the Performance Directorate SharePoint site where they are available to divisional staff at any time. Divisional reports include the KPIs defined within the NHS Wales Delivery Framework that are relevant to the division along with agreed local KPIs. The latest validated position is formally reported to the monthly F&P meetings for discussion, which supports actions to be taken to improve future performance and informs the exception reporting processes of BCUHB IQPR which is also hosted on the Performance Directorate SharePoint site.                                                                                                                                                                                                                                                                                                                                                                                                                 | 17/04/2019 |            | 0 | 13/03/2019 | Closed - Not Verified | Divisional Performance Reports continue to be hosted on the Performance Directorate SharePoint site where they are available to divisional staff at any time. Divisional reports include the KPIs defined within the NHS Wales Delivery Framework that are relevant to the division along with agreed local KPIs. The latest validated position is formally reported to the monthly F&P meetings for discussion, which supports actions to be taken to improve future performance and informs the exception reporting processes of BCUHB IQPR which is also hosted on the Performance Directorate SharePoint site.               |

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| 692 | Internal Audit | East Area Governance Arrangements                                   | 2018/19 | N/A | Medium | Quality and Safety Arrangements                               | To ensure that all reports pertaining to Quality and Safety Issues are provided to the appropriate forums at the allotted time in line with the Terms of Reference of the respective meeting groups. That the use of the Harm Dashboard be encouraged with Senior Managers utilising it on a daily basis so that there is an awareness of issues and that good governance is followed.                                                                                                                                                                            | Accepted and implemented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31/01/2019 |            | 0 | 12/06/2019 | Closed - Not Verified | This action is implemented as described in the update status                                                                                                                                                                                                                                                                                                                                                                                                |
| 693 | Internal Audit | East Area Governance Arrangements                                   | 2018/19 | N/A | High   | Performance Management                                        | The reporting and scrutiny of Performance issues should be in line with the expectations outlined in the Terms of Reference for the Finance and Performance committee, to ensure that the performance management framework is robust and operating effectively.                                                                                                                                                                                                                                                                                                   | This issue should be seen within the context of the BCU wide development of a performance framework for Primary & Community Services. The Area F&P includes a performance report on a monthly basis but not at the level required to meet the TOR. When a corporate performance report is available for Primary and Community Services, this will be cascaded to Area level reviewed within the F&P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/01/2019 |            | 0 | 27/02/2019 | Closed - Not Verified | See update                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 694 | Internal Audit | East Area Governance Arrangements                                   | 2018/19 | N/A | Medium | Governance Arrangement                                        | The Area Director, supported by relevant Area officers: Reviews all Terms of Reference to ensure they remain accurate, fit for purpose and are approved by the establishing group; Ensures the requirements of the Office of the Board Secretary are considered and met in full for all established groups/meetings (where appropriate); Ensures minutes are of a sufficient standard and reflect discussions/scrutiny and outcomes.                                                                                                                              | All TOR will be reviewed by Chair of each group and reported to the December AMG. Area Director to review at December AMG. It should be noted that the governance structure is currently under review as part of the development of a Health Economy governance arrangement. Meetings affected by this review may be subject to a different deadline.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/01/2019 |            | 0 | 17/06/2019 | Closed - Not Verified | This action is complete and in place. Meetings take place in line with the Governance structure and are appropriately recorded.                                                                                                                                                                                                                                                                                                                             |
| 695 | Internal Audit | Annual Report: Performance analysis - Verification of reported data | 2018/19 | N/A | Low    | Data Testing                                                  | Continued verification and update of performance data across the seven performance domains to ensure information within the annual report is presented accurately, clearly and in accordance with Welsh Government Mfa.                                                                                                                                                                                                                                                                                                                                           | The Head of Performance Assurance accepts the findings and recommendation made in this report. We will produce a Standard Operating Procedure (SOP) to ensure processes are standardised, to provide clarity on responsibilities, escalation and sign-off, and as part of the Performance Assurance Team's section of the Directorate's Business Continuity Plan (BCP) (in case of unexpected absence etc.). The SOP can then be included as an Appendix in the Office of the Board Secretary's SOP for producing the Annual Report. The SOP will be produced by 31st July 2018 and a copy sent to Internal Audit as evidence to update/ close this Action.                                                                                                                                                                                                                                                             | 31/07/2018 |            | 0 | 31/07/2018 | Closed - Not Verified | The SOP has been written and tested.                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 700 | Internal Audit | West Locality Compliance with the Budget Setting Methodology        | 2018/19 | N/A | Medium | New Recommendation                                            | Budget setting accountability agreements should be completed by all Chief Finance Officers. Evidence of senior Finance management review and scrutiny should be documented and retained.                                                                                                                                                                                                                                                                                                                                                                          | The completion of Appendix B 'Prophix Budget System Reconciliation' is part of the Budget Setting methodology in 2019/20, and any differences with the Prophix control total or methodology will be shared with the Finance & Performance Committee for agreement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/03/2019 | 20/05/2019 | 2 | 14/08/2019 | Closed - Not Verified | No differences applied within the Budget Setting between the Prophix Control Total and the opening budget                                                                                                                                                                                                                                                                                                                                                   |
| 701 | Internal Audit | West Locality Compliance with the Budget Setting Methodology        | 2018/19 | N/A | Medium | New Recommendation                                            | Management should consider whether the controls in place for setting budgets for vacant posts is sufficiently robust. We acknowledge that a bottom increment approach may not be appropriate for all vacant posts. Management should therefore consider making provision for such instances in the methodology document, and determine the level of controls and oversight over such instances.                                                                                                                                                                   | Any deviation from Prophix for vacancies, the CFO will be required to populate the Prophix System for consideration by the senior Finance management team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/03/2019 | 20/05/2019 | 1 | 21/05/2019 | Closed - Not Verified | CFOs have confirmed they have followed the Budget Setting Methodology and the use of Prophix to set Pay budgets                                                                                                                                                                                                                                                                                                                                             |
| 702 | Internal Audit | Delivery of savings plans                                           | 2018/19 | N/A | High   | Inconsistent Practice                                         | The Health Board should consider whether current practice is sufficiently robust to ensure compliance with the requirements of the Financial Delivery Unit's Current Practice and Future Approach paper. The paper places significant emphasis on inconsistent practices and a move towards standardisation, and will be effective as of the 2019/20 financial year. Whilst we acknowledge the intricacies of individual saving projects, we urge managers to consider developing a Standard Operating Procedure to promote consistent practice and transparency. | Noted. We are currently reviewing standard operating procedures relative to how they support meeting expectations and delivering best practice. This recommendation will be incorporated into the review. The review includes identifying potential improvements to existing procedures, identifying any new procedures that may be required, and identifying any new training requirements for finance and other staff to embed improvement .                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 02/09/2019 |            | 0 | 11/09/2019 | Closed - Not Verified | There is a strong focus on financial recovery and delivery of required savings and other improvements. Appropriate governance mechanisms are in place to ensure delivery and manage risk. There is a well-defined process for challenging, and for identifying and specifying opportunities and schemes, and the range of activities underway and staff involvement at organisational, divisional and thematic levels is embedding a standardised approach. |
| 703 | Internal Audit | Annual Quality Statement                                            | 2018/19 | N/A | Low    | Compliance with WHC Directive WHC /2018/011                   | The AQS should be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance.                                                                                                                                                                                                                                                                                                                                                       | Late 2018 a Business Support Manager will be appointed who will lead / develop the AQS as a main part of their role therefore providing a focus for the document in terms of meeting timescales and content. It is recommended that the development of the AQS begins when all BCUHB Annual Reports have been submitted (End April 2018) as these documents will contain all the information required for the AQS – this will avoid duplication of effort and provide a focused approach for BCUHB in terms of both the AQS and annual report. The option to delay publication until Health Board Divisional Annual Reports have been submitted was raised / highlighted to Welsh Government during the All Wales AQS meeting. During the meeting it was suggested that the AQS publication date be pushed back to the Autumn – no further feedback has been received from Welsh Government or the All Wales AQS Group. | 30/06/2019 | 09/12/2019 | 1 | 28/11/2019 | Closed - Not Verified | The AQS will be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance. To date the guidance has not been recieved, but these actions will be incorporated into the document.                                                                                                                                             |
| 705 | Internal Audit | Infection Prevention and Control - Safe, clean care                 | 2018/19 | N/A | Medium | Mandatory training                                            | The date and availability of Mandatory training sessions should be noted accurately on the appropriate page of the intranet. Efforts should be made to ensure staff receive and complete Mandatory training in line with HB compliance requirements.                                                                                                                                                                                                                                                                                                              | There is no requirement to have training dates on the intranet page as ESR will highlight gaps or laps in training. The IP training is available on line at level one and two. Any additional gaps in specific knowledge the IP teams will put on extra sessions, which will be placed in the BCU Bulletin. To attain the % compliance for the mandatory training of 85% there will be a specific action to improve compliance on the next action tracker for SCC.                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 09/09/2019 |            | 0 | 25/11/2019 | Closed - Not Verified | Mandatory Training is now completed on line with E-learning. Line managers will get the % status of all their staff for compliance. Attached is an example for the nursing teams/.                                                                                                                                                                                                                                                                          |
| 706 | Internal Audit | Infection Prevention and Control - Safe, clean care                 | 2018/19 | N/A | High   | Unannounced Observational Testing of Safe Clean Care on Wards | All wards are routinely reminded to review the essential actions required to uphold SCC and reduce patient infection rates.                                                                                                                                                                                                                                                                                                                                                                                                                                       | Continued plans in place to monitor compliance with SCC IP requirements. Ward accreditation will also be a mechanism to uphold standards required. Spot checks will also continue under SCC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/03/2020 |            | 0 | 25/11/2019 | Closed - Not Verified | As part of the ward accreditations there are unannounced visits to all ward areas. This includes looking at Infection Prevention and practices. The findings are then reported upon from the visiting team and any actions or recommendations are communicated                                                                                                                                                                                              |
| 707 | Internal Audit | Infection Prevention and Control - Safe, clean care                 | 2018/19 | N/A | High   | Safe Clean Care Tracker of expected actions                   | Management should ensure: The responsibility to complete outstanding expected actions is transferred to Area /Secondary Care Management for both Acute and Community, with a commitment to deliver the expected outcome; A risk assessment is completed to identify the risk of non-completion; The completion of expected actions is independently monitored and reported to the Steering Group to ensure SCC is maintained and progress made.                                                                                                                   | The agreement has been made that the Safe Clean Care work will continue and actions will be continually tracked. The Governance monitoring structure is being reviewed but ultimately the Executive board will continue to monitor progress and improvements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30/09/2019 |            | 0 | 27/11/2019 | Closed - Not Verified | All open actions closed on the tracker. Please see attachment and specific comments.                                                                                                                                                                                                                                                                                                                                                                        |



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| 710 | Internal Audit | Delivering the Mental Health strategy                                                                                                     | 2018/19 | N/A | Medium | Delivering the Mental Health strategy                                            | Management ensure the flow of information between all established groups, per the governance structure, is effective and consistent with cycles of business, thus ensuring agenda items are present.                                                                                                                                                                                                                                                                                                                                                                                                | Management Response: We acknowledge that there was limited evidence of the Together for Mental Health Partnership Board (MHPB) formally disseminating information down to the Local Implementation Teams (LIT's) and Quality and Workforce Groups (Q&WFG). In response to this we suggest the following actions: The LIT Chairs together with the newly established Service Improvement Lead will be invited to be 'in attendance' at all T4MHPB. It will be the responsibility of the Service Improvement Lead to provide formal feedback from the Board to the LIT's and Q&W groups. The Chair of the Strategy and Service Redesign Group, who sits on the T4MHPB will be provide formal feedback from the Board to the monthly Strategy and Service Redesign group. Chairs assurance reports have been developed for feedback to the T4MHPB from all reporting groups. In response to improving the communication between the 3 LITs and the Q&W groups we offer the following actions: A new approach for joint working between the LITs and all Q&W groups has been tested where each Q&W group came together at a joint accelerated learning event for whole day. This first event proved to be extremely successful as it improved the potential for collaborative working, expedited decision making processes, ensured that groups take accountability for their work stream and improved communication flows. It is proposed that dates for the year are established and we run these events every 8 weeks. This approach would replace the existing individual meeting of Q&W groups. The reforming of the Mental Health Commissioning Group has been completed with a focus on developing a clear project support pathway for both the LIT's and Q&W groups. Work to develop a commissioning framework will be undertaken by the group that will support both the LIT's and Quality and workforce groups in moving project proposals into business cases and through a collaborative commission framework. There is now an agreed Cycle of Business for the T4MH Board | 30/09/2019 |            | 0 | 15/10/2019 | Closed - Not Verified | all actions have been completed/ implemented unable to upload supporting documentation                                                                                                                                                                                                                                     |
| 711 | Internal Audit | Delivering the Mental Health strategy                                                                                                     | 2018/19 | N/A | High   | Delivering the Mental Health strategy – Project plan and indicators              | The Strategy document is underpinned by a detailed project plan that captures milestones and all activities needed to deliver the required outcomes, so enabling scrutinisation of delivery. Update reports provided to the Strategy, Partnership and Population Health Committee include performance against the stated indicators.                                                                                                                                                                                                                                                                | The LITs are still relatively new in their development and the work that has been undertaken to build trust and confidence across the partnerships in North Wales cannot be underestimated. However, it is acknowledged that the 3 LITs did not have detailed action plans that included activities and milestones. To address this the following actions will be completed: Development of a new project support pathway for the LIT's and Q&W groups to ensure milestones, deliverables, outcomes and impact are captured and monitoring against them can be undertaken effectively. Q&W Groups report bi-monthly to Strategy Service and Redesign Group on milestones & activities against the Delivery Plan. Development of local delivery plans for each LIT will include key milestones and activities to demonstrate delivery against outcomes, these will be reported on in the ISB's and T4MH Partnership Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30/09/2019 |            | 0 | 15/10/2019 | Closed - Not Verified | all actions have been completed. supporting documentation attached                                                                                                                                                                                                                                                         |
| 722 | Internal Audit | Freedom of Information Act (2000)                                                                                                         | 2018/19 | N/A | Medium | Availability of Information                                                      | Location of the Freedom of Information internet page should be reviewed for ease of accessibility. The information held within the Publication Scheme should be reviewed for completeness and accuracy.                                                                                                                                                                                                                                                                                                                                                                                             | Work is already underway to develop new webpages for the Health Board as part of the renewal of the BCUHB website. The Information Governance Team have been involved in this work to ensure all future publications from subject matter experts are reflected as required within the publication scheme. A review of the current position of the Freedom of Information pages to be undertaken between Information Governance and the Communications Team. All links in the current Publication Scheme to be reviewed and updated by the Information Governance Team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/01/2019 | 01/04/2019 | 2 | 02/04/2019 | Closed - Not Verified | All actions completed. See status update                                                                                                                                                                                                                                                                                   |
| 723 | Internal Audit | Freedom of Information Act (2000)                                                                                                         | 2018/19 | N/A | Medium | Datix updated and complete                                                       | Datix should be used to store a complete audit trail of the request and all details should be updated as soon as practicable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | There has been a technical fault with DATIX which has led to an inability to load documents or emails into the documents folder. Information Governance Manager to resolve fault with IT and Integrated Governance Manager. Information Governance Team to recommence and adhere to the standard operating procedure which will be monitored.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/01/2019 |            | 0 | 31/01/2019 | Closed - Not Verified | see attached evidence in update section                                                                                                                                                                                                                                                                                    |
| 728 | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | High   | Catering, hydration and nutrition performance - Reporting to the Board/Committee | Management review the current collection of catering, nutrition and hydration data and identify where it could/should be reported and frequency for assurance purposes.                                                                                                                                                                                                                                                                                                                                                                                                                             | The following performance reports will be reviewed and made available to QSG: Catering waste reports - Ward accreditation scores relating to nutrition (once agreed process is in place, as above). Compliance with mandatory training e-learning FRC package. This will form an agenda item at INCHS on the 7th December 2018 (next quarterly meeting) and the mechanism for obtaining the information and reporting arrangements will be identified from that meeting. Reporting arrangements will be in place by June 2019.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 30/06/2019 | 18/07/2019 | 1 | 17/07/2019 | Closed - Not Verified | From September 2019 INCHS                                                                                                                                                                                                                                                                                                  |
| 729 | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | Medium | Financial/EFPMS data - service delivery                                          | The Health Board reviews the requirements for non-patient catering services and whether it formally subsidises as welfare service or an income generation activity.                                                                                                                                                                                                                                                                                                                                                                                                                                 | A paper will be presented to the Executive Management Group (EMG) by the Director of Estates & Facilities to determine the direction the organisation wants to go in regards to the provision of Non Patient Retail Catering. If the EMG agree that the service should be provided as a subsidies service a Health Board policy will be required to underpin the operational and financial requirements of the service being delivered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/01/2019 | 31/07/2019 | 2 | 05/11/2019 | Closed - Not Verified | Final action requires closing. Retail catering is not subsidised from the patient feeding budget.                                                                                                                                                                                                                          |
| 736 | Internal Audit | Staffing costs - Review of staff earning more than £200,000                                                                               | 2018/19 | N/A | High   | Manual arrear payment                                                            | The Health Board reviews the process followed for paying the manual payment and ensures, if relevant, it complies the Scheme of Delegation - Delegated Matter 17 - Losses, Write-offs and Compensation.                                                                                                                                                                                                                                                                                                                                                                                             | This payment related to back pay, and there was an offer made by the employee's representative to accept a lower amount, in order to facilitate resolution. This payment was therefore processed as pay arrears in good faith. However advice will be taken for future arrears payments where a lower amount is negotiated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/07/2018 |            | 0 | 29/10/2018 | Closed - Not Verified | Response related to future manual payments so no further actions to be taken at present.                                                                                                                                                                                                                                   |
| 737 | Internal Audit | Staffing costs - Review of staff earning more than £200,000                                                                               | 2018/19 | N/A | Medium | Pensionable/Non-pensionable pay element                                          | Management review the guidelines developed which set-out when pensionable/non-pensionable pay elements are to be used and obtain guidance from the Office of the Board Secretary whether these should be formally considered by RATS Committee. All relevant line managers are advised of the guidelines when agreeing contractual changes. Management review, based on risk and cost, the pay elements detailed in appendix c of this report and consider whether individuals are in receipt of the correct pay element – this may have a negative/positive cost implication for the Health Board. | A review will be undertaken of the management guidance relating to pensionable / non pensionable pay elements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 30/11/2018 |            | 0 | 11/03/2019 | Closed - Not Verified | A review of Pensionable/non pensionable items commenced in October 2018 in conjunction with NWSSP. A list confirming which payments fell into which category was issued to all medical workforce team members with a responsibility for ESR amendments. The list will be reviewed annually at the launch of each tax year. |
| 738 | Internal Audit | Case management and disciplinary process                                                                                                  | 2018/19 | N/A | Medium | Record of Investigating Officers and training provided                           | A central repository maintained of all available investigating officers and when they completed/received the relevant ASIM/equivalent training.                                                                                                                                                                                                                                                                                                                                                                                                                                                     | All ASIM training is routinely recorded on ESR. External investigating officers received bespoke training on appointment. However their use is currently being phased out, and they will only be utilised in exceptional circumstances. A central record will be developed of investigating officers, but dates may not be available for those who have been trained for some time and conduct investigations regularly.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 08/05/2019 |            | 0 | 16/05/2019 | Closed - Not Verified | A record has been developed from ESR on all investigating officer training dates. this will not include investigating officers training prior to ESR records being in place.                                                                                                                                               |
| 739 | Internal Audit | Case management and disciplinary process                                                                                                  | 2018/19 | N/A | Medium | Monitoring arrangements                                                          | The COM1 form is mandated for completion and additional section added for completion and signing by the Investigation Officer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Cases are monitored monthly by the Assistant Director HR and Executive Director of Workforce and Organisational Development. Exception reports are produced by Heads of Workforce for all cases of over 12 weeks' duration. The COM1 form is not optional, and staff will be reminded that this must be completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 08/05/2019 |            | 0 | 16/05/2019 | Closed - Not Verified | Cases are monitored monthly. staff have been reminded that the COM 1 must be submitted,                                                                                                                                                                                                                                    |
| 740 | Internal Audit | Case management and disciplinary process                                                                                                  | 2018/19 | N/A | High   | Investigation files and File retention                                           | A central document repository for investigation files (electronic) with clear retention timelines for deletions set up for access by the Workforce and Organisational Development department. This ensures that all documentation is stored in a central location with a clear destruction schedule to ensure compliance with GDPR/DPA.                                                                                                                                                                                                                                                             | This will be investigated in conjunction with IT to ensure an electronic solution with sufficient storage space.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 08/03/2019 |            | 0 | 30/09/2019 | Closed - Not Verified | All live case files saved in central folder. see status update                                                                                                                                                                                                                                                             |
| 741 | Internal Audit | Case management and disciplinary process                                                                                                  | 2018/19 | N/A | High   | Recording of timelines                                                           | All details of case timelines and reasons for delays should be recorded to ensure that cases are concluded in a timely manner for both individual and service. There should be a clear process to ensure all delays are subject to follow-up with summary data reported.                                                                                                                                                                                                                                                                                                                            | Cases are monitored monthly by the Assistant Director HR and Executive Director of Workforce and Organisational Development. Exception reports are produced by Heads of Workforce for all cases of over 12 weeks' duration. A tracker has been developed with more detailed timelines than available in ESR. This will more clearly demonstrate where delays occur. This will be operational from January 2019.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 08/05/2019 |            | 0 | 30/09/2019 | Closed - Not Verified | Tracker is a password protected document, saved in a restricted folder on the WOD senior leadership drive. This is subject to the normal network security and resilience mechanisms. A review of those with access is undertaken on a regular basis (minimum quarterly, unless leavers from the team)                      |

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| 742 | Internal Audit | Environmental Sustainability Report                                        | 2018/19 | N/A | Medium | Detail in support of reported figures                      | Improved level of detail with regard to the factors affecting trends over time in respect of the consumption of resources and generation of waste as listed in the respective tables, in line with the guidance within the NHS Wales Manual for Accounts                                                                                                                                                                               | As part of the Health Boards data gathering and reporting requirements for the Annual Sustainability Reports for 2018/19, a narrative and trend profile will be included to explain and illustrate variation over annual reporting periods. This will include information in regards to improvements and/or deterioration in performance set against the Health Boards sustainability objectives.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 29/04/2019 | 30/06/2019 | 1 | 29/01/2020 | Closed - Not Verified | All actions are now completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 746 | Internal Audit | Booking of medical agency staff                                            | 2018/19 | N/A | High   | Agency staff engagements outside the managed service       | Controls and procedures for the engagement and monitoring of agency staff outside the managed service arrangements should be developed and properly embedded across the Health Board.                                                                                                                                                                                                                                                  | As part of the Welsh Government implementation of Capped Rates for External Agency Locums, as per Welsh Health Circular WHC-17-042, an extensive communications plan was executed. During the implementation in October and November 2017, Clinical Directors, Clinical Leads, Rota Co-ordinators and other key stakeholders such as finance and WOD received individual letters and email communications with regards to the changes and actions required on a local basis both from Executive Medical Director and from the Head of Medical Workforce. A number of associated documents are detailed on the Executive Medical Director Intranet pages. This information will be circulated again to the Clinical Directors, Clinical Leads and Rota Co-ordinators.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28/02/2019 |            | 0 | 11/03/2019 | Closed - Not Verified | Information relating to the standard operating procedures and the Welsh Health Circular, have been re-shared with clinical managers, clinical leads, rota co-ordinators in November 2018. This information will be re-circulated quarterly to remind everyone of their responsibilities under the process.                                                                                                                                                                                                                                                                                                                                                                            |
| 747 | Internal Audit | Booking of medical agency staff                                            | 2018/19 | N/A | High   | Processes for Booking Agency Staff                         | The Medical Agency Locum Appointments (BCUHB) Agency Locum SOP (MD 01) is reviewed, updated and disseminated to all relevant officers across the Health Board to ensure internal controls in respect of booking Agency staff are adhered to in full. MASDA fields are made mandatory and data is reviewed in full and gaps in rationale against the expected steps in the SOP identified and rectified prior to approving the booking. | The SOP will be reviewed and updated. MASD A fields are made mandatory so that all information has to be identified before approving the booking or an alternative booking system will be introduced.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/03/2019 |            | 0 | 11/03/2019 | Closed - Not Verified | The SOP was reviewed and updated in November 2018 and uploaded to the Intranet pages. The information was sent to all clinical directors, clinical leads, rota co-ordinators. In future a quarterley reminder will be sent to remind all of their responsibilities under the SOP.                                                                                                                                                                                                                                                                                                                                                                                                     |
| 756 | Internal Audit | Health and Safety                                                          | 2019/20 | N/A | Medium | Gap Analysis                                               | Management, on the back of their first gap analysis exercise, reflect on the process/experience and consider whether there are opportunities to improve, noting our findings as part of this review.                                                                                                                                                                                                                                   | A thorough review of the process will be undertaken to ensure that it is clear who has roles and responsibilities on site. This will be achieved through a comprehensive review of actions identified from the gap analysis review. Another full audit will be undertaken in September 2020 with all issues addressed as described above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31/10/2020 |            | 0 | 21/11/2019 | Closed - Not Verified | There has been an internal audit the findings of which were accepted at the Strategic OHS Group and will be addressed in the future gap analysis which will be undertaken in September 2020. A 12 month action plan has been developed to address the actions identified in the gap analysis and progress will be monitored by the Strategic OHS Group.                                                                                                                                                                                                                                                                                                                               |
| 757 | Internal Audit | Health and Safety                                                          | 2019/20 | N/A | High   | Governance                                                 | The requirements set out within Health Board Policy HS01 – Health and Safety Policy are complied with at all times.                                                                                                                                                                                                                                                                                                                    | The Policy requires a complete review to ensure the roles and responsibilities of BCUHB leadership are clear on all Health and Safety legislation. The systems will be implemented to ensure effective monitoring of the safety management process is in place. The Strategic Occupational Health and Safety Group will monitor the Divisions/organisations accidents and safety performance activities with clear terms of reference and Trade Union Partners support.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30/11/2019 |            | 0 | 21/11/2019 | Closed - Not Verified | The H&S Policy has had a complete review from September 2019. The roles and responsibilities within the Policy are clearly stipulated. The Strategic OHS Group will monitor the organisations accidents and safety performance activities with clear TOR and Trade Union Partners support. Policy awaiting final sign off QSE Jan 2020. Already approved at Strategic OHS Group in November 2019 .                                                                                                                                                                                                                                                                                    |
| 761 | Internal Audit | SFI Compliance – Procuring goods and services: Estates - GRAMMS            | 2019/20 | N/A | High   | Compliance with Operational Estates Procedure No 01.       | Management should reinforce, to all relevant officers the requirements of the revised Estates procedure No 01 and/or the Health Board Standing Financial Instructions when goods and services are procured.                                                                                                                                                                                                                            | The Operational Estates Business Support Unit Operational Procedure No.1 – Quotation Procedure will be further amended to clearly detail how the opening of e.mailed quotations shall be dealt with and recorded. This change to the procedure will be communicated and discussed within the local East, Centre, West finance meetings with the staff concerned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11/11/2019 |            | 0 | 21/11/2019 | Closed - Not Verified | Action completed and Procedure Implemented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 762 | Internal Audit | SFI Compliance – Procuring goods and services: Therapies – Therapy Manager | 2019/20 | N/A | High   | Compliance with the Standing Financial Instructions [SFIs] | The Orthotics Department ensures compliance with the requirements of the SFI's in procuring goods and services, with attention paid to the requirements detailed in Schedule 1 – Procurement of works, goods and services: Supplementary guidance.                                                                                                                                                                                     | There has been immediate implementation of new process to mitigate this risk whilst we await the initiation of E-financial procurement. Clinicians have been instructed that for any order estimated to cost more than £2000 a written quotation will be required. If this quotation is greater £4500 we will proceed to invite quotes in accordance with the LHB's quotation procedure bar where procedure exceptions apply. Quotes between £2000 and £4500 will be reviewed by the Head of Service and Area Director of Therapies for approval. Clinical information will be sought to ensure that the device is appropriate. The transfer to E-procurement is in progress for implementation as soon as procurement services can facilitate this. This will be begin before the end of 2019. This process forms part of the All Wales procurement for Orthotics using their recommended suppliers. Every individual order will have a quote for Head of Service Approval before the order is placed to mitigate against any future noncompliance of the requirements of the SFI's in procuring goods and services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 30/09/2019 |            | 0 | 25/11/2019 | Closed - Not Verified | The transfer of orthotics orders across BCUHB onto oracle for transparency and audit has now been implemented. The orders are approved by the Head of Service within each area.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 773 | Internal Audit | Annual Quality Statement                                                   | 2019/20 | N/A | High   | Data Testing                                               | Reporting of data through Committee and Board papers must be from the same source.                                                                                                                                                                                                                                                                                                                                                     | As a National Measure, the Number of Falls reported as Serious Incidents has now been removed from the NHS Wales Delivery Framework for 2019/20, however it is still being monitored as a Local Measure in the Integrated Quality & Performance Report (IQPR) for both Quality, Safety & Experience Committee and to the Board. As such reporting has been reviewed and strengthened and data now comes from a single source within the Health Board. The Performance Team is in the process of producing Standard Operating Procedures (SOPs) for each and every Measure that is reported via the IQPR and these will be shared with our partners whom provide the data/information for us. The 2019/20 NHS Delivery Framework was published in May 2019 and Welsh Government (WG) are continuing to make revisions to it. Not all of the Measures within the Framework have associated Data Set Change Notices (DSCN) and we are working with WG to expedite those orphan measures. Although we expect to complete all the SOPs by the 30 <sup>th</sup> September 2019, this will be an ongoing process and where new Measures are published in-year, we will endeavour to have the SOP written up and shared within 1 month of publication of the Measure. This may seem late in the year, however the NHS Wales Delivery Framework for 2020/21 isn't expected to change much compared to 2019/20 so these SOPs will be relevant for at least 18 months after completion. However we are committed to reviewing all our SOPs on an annual basis as part of our Cycle of Business and in addition we continuously scan for updates or amendments to the Measures from WG whereupon we will amend our SOPs accordingly within 1 month of those changes being published. | 30/09/2019 |            | 0 | 15/11/2019 | Closed - Not Verified | Issues regarding receipt of data from multiple sources has been resolved. Continued development of SOPs ensure maintenance of good governance. Controls in place, risk minimised.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 774 | Internal Audit | Annual Quality Statement                                                   | 2019/20 | N/A | Low    | Compliance with WHC/2019/007                               | The AQS should needs to published in line with guidance WHC/2019/007                                                                                                                                                                                                                                                                                                                                                                   | The post of Business Manager for Corporate Nursing is now recruited too. The development of the AQS is one of the core responsibilities within the role on behalf of the Executive Director for Nursing and Midwifery this role will provide project management support and consistency to its development. All Wales meeting planned for September 2019 to review future AQS development.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/10/2019 | 31/01/2020 | 2 | 23/12/2020 | Closed - Not Verified | The Welsh Health Circular was received from Welsh Government on 23 December 2019 and sets the guidance for the AQS 2019-20. The AQS working group is in progress and have discussed the WHC guidance in detail. The Business Manager, Corporate Nursing is project managing the AQS and is continuously referring to the WHC criteria to ensure all standards are met. The management of the project commenced in December. The WHC confirms that the Health & Social Care (Quality & Engagement) (Wales) Bill includes new reporting requirements which will build on and replace the existing AQS moving forward. Therefore, this recommendation has been successfully implemented. |
| 783 | Internal Audit | GDPR – Follow-up of the Information Commissioners Office (ICO) review      | 2019/20 | N/A | Medium | Reporting                                                  | Management should consider providing periodic updates of action plan progress and issues to the Digital and Information Governance and Informatics committee. Management should also ensure that all key policies and guidance notes are reviewed and updated accordingly.                                                                                                                                                             | ICO Follow up audit report to be submitted to the Information Governance Group, noting outstanding actions transferred and monitored via the IG and Health Records Work Programmes. ICO Follow up report and IGG Chairs Assurance Report to D&IGC to provide update on report and progress on outstanding actions. IG01 to be finalised, submitted to IGG, published on the Intranet site and disseminated to all staff. IG04 approved version to be published on the Intranet and disseminated to all staff.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 21/11/2019 |            | 0 | 25/11/2019 | Closed - Not Verified | Please see all evidence and comments submitted as part of update section                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 790 | Internal Audit | Non-Emergency Patient Transport Service (NEPTS)                            | 2019/20 | N/A | High   | Governance of providers                                    | Health Board operational management must ensure that only approved providers are allowed to undertake patient transfers, and that they have signed up to the necessary Terms & Conditions.                                                                                                                                                                                                                                             | Communication has been circulated to all site leads requesting that only approved providers are allowed to undertake patient transfers. If any record of such arrangements are identified in the future they will be escalated accordingly.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/04/2020 |            | 0 | 29/04/2020 | Closed - Not Verified | This matter was closed in January 2020. Site leads were informed not to direct award, and further investigation of the one suspected case revealed the company was being commissioned by Welsh Ambulance rather than the Health Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|      |                |                                                                           |         |     |        |                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            |            |   |            |                       |                                                                                                                                                                                                                                                                                                        |
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| 791  | Internal Audit | Non-Emergency Patient Transport Service (NEPTS)                           | 2019/20 | N/A | Medium | Reporting structure & Capture and sharing of data                               | Tier 2 pan-Health Board group re-established to review monthly NEPTS performance against the nationally agreed standards, and to support in the development of solutions that will promote performance and patient experience improvements. The requirement for Tier 3 meetings are reviewed and where service needs identify a risk are re-established.                                                                     | Fully support the importance of this forum, and that it needs to be a partnership between both the Health Board and Welsh Ambulance transport leads. This Tier 2 pan-Health Board group has now been re-established, the first meeting held on 21/01/2020 with subsequent monthly meetings now scheduled for 2020. One concern raised at this forum is that there continues to be a lack of clarity surrounding a pan-BCU Lead for NEPTS. This has been escalated from the Tier-2 group to the Contracts Review and Governance group, which feeds into the Finance & Performance Committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/04/2020 |            | 0 | 29/04/2020 | Closed - Not Verified | This has now been implemented, with the NEPTS Review & Development Group reformed and first meeting of 2020 was on 18th February. Monthly meetings are in the calendar for 2020.                                                                                                                       |
| 798  | Internal Audit | Environmental Sustainability Report                                       | 2019/20 | N/A | Medium | Quality Review of the Environmental Sustainability Report                       | A thorough quality review of the Environmental Sustainability Report should be undertaken by management before it is published to confirm compliance with Welsh Government and HM Treasury guidance and to ensure completeness and accuracy. Nominated officers should ensure they provide relevant and accurate information and evidence to support the statements included within the Environmental Sustainability Report. | A quality check stage will be introduced to validate the selection criteria used and content of inputted data so as to ensure compliance with Welsh Government and HM Treasury guidance and to ensure completeness and accuracy. This will be carried out by an independent member of staff not involved in the initial data collection. Ensure that nominated officers provide relevant and accurate information and evidence to support the statements included within the Environmental Sustainability Report. Ensure that the data collection spreadsheets for the East area are rationalised and standardised in the format as used by Central and West areas.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 30/06/2020 |            | 0 | 12/06/2020 | Closed - Not Verified | Management has introduced a number of checks on data quality and compliance with WG Guidance. The sustainability report for 2019-20 has been completed and submitted for corporate sign off.                                                                                                           |
| 800  | Internal Audit | Statutory Compliance: Fire Safety                                         | 2019/20 | N/A | Medium | Governance                                                                      | The governance and accountability structure is not formally recorded and approved.                                                                                                                                                                                                                                                                                                                                           | The Fire Safety Management Group will review the current terms of reference to reflect the updated reporting governance through the Strategic Occupational Health and Safety Group and record this on the BCUHB template. The Chair of the Fire Safety Management Group (FSMG) will advise the Strategic Occupational Health and Safety Group that the FSMG is not recorded within its sub group structure and is required to be included. (It is noted that the Head of Health and Safety is a member of the FSMG).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 30/11/2019 | 31/12/2019 | 1 | 09/01/2020 | Closed - Not Verified | Latest amendment of the Health and Safety Policy is attached which has been approved by SOHSG. It refers to the FSMG as a sub group of SOHSG. The Terms of Reference were approved in the meeting held on 03/12/2019.                                                                                  |
| 803  | Internal Audit | Ysbyty Gwynedd Emergency Department Patient Monitors                      | 2019/20 | N/A | High   | Maximising procurement savings                                                  | Secondary Care management, in partnership with Procurement Services, identify its consumable needs, Health Board wide, to maximise opportunities for driving down consumable related costs from Supplier b.                                                                                                                                                                                                                  | Following procurement review of processes we can confirm that: • PPIB tool used for benchmarking • ED department diligence on 'generic' use items, OEM • New All Wales contract September are in practice and also a link across to procurement saving plans BCUHB wide for all Philips and other consumables. Embedded is evidence (APPENDIX C) of the work done through the ED procurement of monitoring which demonstrates the scrutiny and detail available to ensure value for money is maximised.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 16/09/2019 |            | 0 | 13/11/2019 | Closed - Not Verified | Completed                                                                                                                                                                                                                                                                                              |
| 805  | Internal Audit | Ysbyty Gwynedd Emergency Department Patient Monitors                      | 2019/20 | N/A | High   | Secondary Care procurement                                                      | Secondary Care management Team ensure it has controls and governance processes embedded to ensure its approach to standardisation of equipment is consistent to deliver interoperability etc.                                                                                                                                                                                                                                | The Head of Procurement has suggested that the HB consider including a "Procurement" section in its Capital Business Case template which could include questions such as; 'Is this compliant with standardisation strategy?' 'What is the route to market? eg Tender/ Quote/Contract/framework'. This suggestion has been forwarded to the Executive Director of Planning and Performance to consider implementing the changes as suggested here in. In the short term Procurement will seek to police all requests that they are made aware of and will not embark on any procurement exercises regardless of the source without escalating to the DoF should the drive for standardisation be challenged. In addition Secondary Care are in the process of reviewing its equipment trial grip and control on each acute site. Interim arrangements require the Managing Directors to work closely with their operational and clinical teams to identify all areas where equipment trials are in play or planned in the near future, and report upwards to the Secondary Care management team to ensure consistent approach across BCU. The corporate governance structure of secondary care has recently undergone a review with the introduction of a monthly service development group. Trials will be reported through this group, Draft ToR attached (APPENDIX E), to be ratified at next meeting (24th July 2019). | 16/09/2019 |            | 0 | 29/11/2019 | Closed - Not Verified | See status update. Secondary care service delivery group meets monthly, TOR have been ratified.                                                                                                                                                                                                        |
| 1089 | Internal Audit | Ysbyty Glan Clwyd                                                         | 2015/16 | N/A | High   | Disputed sums                                                                   | An action plan will be produced to manage current disputed issues to an early conclusion.                                                                                                                                                                                                                                                                                                                                    | Agreed. Actions are currently being progressed to resolve outstanding disputes. The timeframe for resolution of some aspects e.g. inflation, will be dependent upon the contractual route required to achieve resolution which will reflect legal opinion.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30/09/2017 | 02/04/2018 | 1 | 28/03/2018 | Closed - Not Verified | Actions agreed to resolve all outstanding items. Agreement of outstanding items, and impact on cost, monitored through monthly cost reports (expenditure of unallocated budget).                                                                                                                       |
| 1090 | Internal Audit | Ysbyty Glan Clwyd                                                         | 2015/16 | N/A | High   | Compensation Event funding source                                               | Compensation Events will identify funding sources as appropriate                                                                                                                                                                                                                                                                                                                                                             | Agreed. Control documents for Compensation Events and PMIs will be reviewed to ensure that there is sufficient analysis of cause and funding source. The scheme of delegation will be reviewed in light of the revised programme limits and compliance will be reviewed on an on-going basis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/07/2017 |            | 0 | 26/10/2017 | Closed - Not Verified | Control documents for PMIs and CEs have been reviewed to incorporate details of thematic cause. Funding source is identified on all CEs and PMIs approved by the Project Director.                                                                                                                     |
| 1113 | Internal Audit | Ysbyty Gwynedd A&E                                                        | 2017/18 | N/A | Medium | Retention of Documents                                                          | The UHB will ensure the retention of key project documentation in accordance with SFIs and the UHBs' Corporate Record Retention and Destruction policies. All project documentation should be held centrally.                                                                                                                                                                                                                | Agreed with Assistant Director of Strategy Capital in email dated 21st August 2018                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28/09/2018 |            | 0 | 25/02/2019 | Closed - Not Verified | Compliant with these standards                                                                                                                                                                                                                                                                         |
| 1116 | Internal Audit | Ysbyty Gwynedd A&E                                                        | 2017/18 | N/A | Medium | Project Management Tools                                                        | A management control plan (MCP) will be prepared to co-ordinate, outline the duration and lead responsibility for key activities required to deliver the project. The risk register will be consistently completed to ensure all necessary information is captured to assist risk management.                                                                                                                                | Actions to be implemented by Project Director as confirmed by Assistant Director of Strategy Capital in email dated 21st August 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28/09/2018 |            | 0 | 25/02/2019 | Closed - Not Verified | Update and completion of risk register now in place                                                                                                                                                                                                                                                    |
| 1122 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Nurse Staffing Levels and Escalation Plan and Recording of breaches on Safecare | The NSL and escalation Plan should be reviewed to provide clear instruction on what constitutes a marginal and major breach of the NSL and any associated harms and should clearly state which system(s) should be used to record breaches.                                                                                                                                                                                  | The Nurse Staffing Levels (Wales) Act 2016, and the All Wales Operational Guidance (2018) (and updated draft Feb 2019) (attached), do not reference a major or marginal breach. The Act sections 13 – 17 outlines the steps Health Boards must take, the systems and reporting requirements when the number of nurses deployed varies from the planned roster. The NSL and escalation Plan will therefore be updated in line with the proposed revised all Wales guidance, with local agreement, approved by the Executive Director of Nursing and Midwifery as to the reporting of non-compliance across Secondary Care as outlined on page 22 and 23 of the guidance. Variation from the planned roster must be entered into Safe Care and on Datix and the NSL policy will be updated to articulate this, with required communication to staff. The E Roster team have confirmed there is the option to add notes to the current SafeCare system, which can be used to record the Datix number so the red flag system and Datix correlate. The All Wales Nurse Staffing group have approved the recommendations within the report (attached) which outlines changes to the complaints and incident management processes.                                                                                                                                                                                               | 10/09/2019 |            | 0 | 30/09/2019 | Closed - Not Verified | The HB's Policy - Nurse staffing levels has been amended and these definitions have been removed.                                                                                                                                                                                                      |
| 1125 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Safecare Training and Operational guidance for Nurse staffing levels            | All Ward staff to be fully trained to use Safecare in line with the requirements of Operational Guidance.                                                                                                                                                                                                                                                                                                                    | Safe care was in the process of being implemented in Wrexham at the time of the audit, which included training of staff. Overall training compliance for Wrexham is 77%, including Evington 63% and Fleming is 82%. In Evington of the 3 staff not trained two work predominately nights and 1 has been off long term sick. Two staff outstanding in Fleming of which one is predominately nights and the other on maternity leave. Where the E Rostering team have been unable to cascade the training to staff, wards have been able to do this. The E Roster team will continue to provide training in the use of Safe Care. The Heads of Nursing will undertake a spot check audit of staff understanding and application in practice on a day to day basis of the Safe Care system. This will be monitored through secondary care accountability meetings.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10/09/2019 |            | 0 | 17/09/2019 | Closed - Not Verified | training has been provided on all 3 sites, further cascade training has also been implemented. there will be the provision of training for new starters or where a refresher is required, no further large scale training events planned.                                                              |
| 1126 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 | 2018/19 | N/A | High   | Nurse staffing levels and shift times                                           | Wards comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act.                                                                                                                                                                                                                                                                                                     | The E Rostering team have been working with Secondary Care Nurse Directors to ensure the E Roster templates comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act. All templates have now been updated in the system to reflect the staffing numbers agreed by the Board in October 2018. There remain discrepancies with the shift times actually worked by the wards versus the hours they are budgeted for which are being addressed by the Nurse Roster Optimisation project. As this is a Health Board wide project, formal consultation on the proposals is necessary, which will occur end March 2019. Subject to the necessary executive approvals, the planned changes, would come into effect on the 4th August Roster due to the 6 week in advance shift approval requirements and the time required for the E Roster team to make the changes in the system. The revised NSL policy will include a section on agreeing and changing templates.                                                                                                                                                                                                                                                                                                                                                                                                    | 10/09/2019 |            | 0 | 17/09/2019 | Closed - Not Verified | mitigations in place: SC and Sites has staffing cited on their Risk Registers Adult Staffing policy in place (although under review) Daily harm reviews 3 times daily staffing reviews utilising safe care annual establishment reviews establishment reviews in line with service change harm reports |

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| 1127 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016                                              | 2018/19 | N/A | High   | Populating Safecare and Datix Incident reporting                     | Management ensure Safecare is used in accordance with guidance and red flag events and harms are recorded appropriately.                                                                                                                                                                                                                                                                                                                                          | Secondary Care Site nurse directors will ensure all staff aware of the requirements to ensure SafeCare is used in accordance with guidance. This will be via Heads of Nursing, Matron, Ward Manager meetings and daily staffing huddle. The Guidance for SafeCare will be re-circulated and reinforced by E Rostering team in training events, that red flag events and harms are recorded appropriately. The E Roster team continue to provide training for new staff and wards are able to cascade the training to staff that the E Rostering team have been unable to directly provide this too. User guides are also available on the E Roster website.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/09/2019 |            | 0 | 30/09/2019 | Closed - Not Verified | safecare training has been completed, all sites monitored as to the use of safecare addressed via bed meetings and roster scrutiny meetings. monthly reports to SCQSG regards staffing related harms.                                                                                                                                                                                             |
| 1128 | Internal Audit | Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016                                              | 2018/19 | N/A | Medium | Funding and Staffing Strategy                                        | Management to review escalation bed management to ensure compliance with the Health Board policies and operational requirements                                                                                                                                                                                                                                                                                                                                   | Secondary Care Hospital Directors in conjunction with Secondary Care Site Nurse Directors to review their bed escalation policies to ensure core bed base and escalated bed base staffing to meet Act requirements are included.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10/09/2019 | 28/11/2019 | 4 | 28/11/2019 | Closed - Not Verified | Secondary Care Hospital Directors in conjunction with Secondary Care Site Nurse Directors have reviewed their bed escalation policies to ensure core bed base and escalated bed base staffing meets the requirements of the Act.                                                                                                                                                                  |
| 1147 | Internal Audit | Annual Quality Statement                                                                                               | 2018/19 | N/A | Low    | Compliance with WHC Directive WHC /2018/011                          | The AQS should be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance.                                                                                                                                                                                                                                                       | Late 2018 a Business Support Manager will be appointed who will lead / develop the AQS as a main part of their role therefore providing a focus for the document in terms of meeting timescales and content. It is recommended that the development of the AQS begins when all BCUHB Annual Reports have been submitted (End April 2018) as these documents will contain all the information required for the AQS – this will avoid duplication of effort and provide a focused approach for BCUHB in terms of both the AQS and annual report. The option to delay publication until Health Board Divisional Annual Reports have been submitted was raised / highlighted to Welsh Government during the All Wales AQS meeting. During the meeting it was suggested that the AQS publication date be pushed back to the Autumn – no further feedback has been received from Welsh Government or the All Wales AQS Group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/06/2019 | 09/12/2019 | 1 | 28/11/2019 | Closed - Not Verified | The AQS will be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance. To date the guidance has not been received, but these actions will be incorporated into the document.                                                                                   |
| 709  | Internal Audit | The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress | 2018/19 | N/A | Low    | Datix administration                                                 | Whilst the variances in our sample were not material, it is imperative that the primary complaints date recorded in Datix is accurate as all key reporting deadline dates are derived from this. Management must ensure all dates recorded in Datix are accurate.                                                                                                                                                                                                 | Reminder to all corporate concerns staff registering complaints that the date recorded on Datix must be the date that the HB first receive the complaint notification and not the date it is registered. The Corporate Concerns Hub will conduct a twice yearly snapshot audit and report the findings to the Head of Complaints.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/07/2019 |            | 0 | 10/09/2019 | Closed - Verified     | A standard operating procedure has been developed to assist in the timeliness of logging complaints by the date of receipt into the organisation. a twice yearly audit will be undertaken by the Corporate Concerns Hub to ensure compliance with the first audit planned for September 2019. The results will be provided to the Head of Complaints for review and action where necessary.       |
| 720  | Internal Audit | Implementing the Falls strategy                                                                                        | 2018/19 | N/A | Low    | Review the DATIX reporting system and the reporting of patient falls | Further development and co-ordination of the intranet as a key repository for all staff.                                                                                                                                                                                                                                                                                                                                                                          | The Falls Prevention Homepage on the BCUHB intranet was under construction at time of audit, the intranet navigation regarding Falls Prevention was not efficient or comprehensive at the time. This is still an ongoing project in collaboration with the Integrated Care Coordinator, with a work stream action plan and end date of 31st December 2018. This will correlate with the 90 Day unscheduled care plan and allow a launch and awareness campaign of the Falls Prevention Homepage in January 2019.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/01/2019 |            | 0 | 11/02/2019 | Closed - Verified     | Completed                                                                                                                                                                                                                                                                                                                                                                                         |
| 744  | Internal Audit | Primary Care GP Leases: Assigning leases to the Health Board                                                           | 2018/19 | N/A | High   | Reviewing of the business cases for GP leases                        | All business cases submitted follow the Revenue Business Cases Guidance and Template (September 2017) as agreed by the Executive Management Group.                                                                                                                                                                                                                                                                                                                | The Business Case guidance has been used as a reference for reassignment of GP Practice leases for those approvals required after September 2017. The guidance was not available for lease transfers required before that date. The Guidance and template will be used for all such recommendations going forward as required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 15/02/2019 |            | 0 | 18/02/2019 | Closed - Verified     | The business case template will be used as required. The transfer of leases is an ad hoc requirement.                                                                                                                                                                                                                                                                                             |
| 745  | Internal Audit | Primary Care GP Leases: Assigning leases to the Health Board                                                           | 2018/19 | N/A | High   | Reviewing and approving business cases                               | In accordance with Standing Order 8.0.1 and Schedule 1 – Scheme of Reservation and Delegation of Powers [Table B – Scheme of Financial Delegation] “£0.5m plus or any which need signing under seal (Reservation of Power, Number 33)” all leases should be considered and approved by the Board. Management provide evidence that the business case for the Connahs Quay practice has been considered and approved by the Finance & Performance Committee/Board. | Contact has been made with the Director of Estates who has said the paper needs CEO sign off. A request has been made for the paper to go again to F&P asap. Date is awaited but this is urgently required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 31/01/2019 |            | 0 | 17/02/2019 | Closed - Verified     | This was approved by the F&P and the Board in January 2019.                                                                                                                                                                                                                                                                                                                                       |
| 748  | Internal Audit | Tendering for goods and services – Estates Department                                                                  | 2018/19 | N/A | High   | Management review of working practices at Wrexham Maelor Estates     | Management undertake a root and branch review of the processes being followed and whether any further action needs to be undertaken.                                                                                                                                                                                                                                                                                                                              | The Director of Estates and Facilities has under the Health Boards Disciplinary Policy Procedure (WP9) instigated an Internal Investigation into the significant issues of concern raised within this Internal Audit Report.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/03/2019 | 13/05/2019 | 1 | 15/05/2019 | Closed - Verified     | Under the Health Boards Disciplinary Procedures WP9 the Investigation has now been completed and due process will now follow.                                                                                                                                                                                                                                                                     |
| 749  | Internal Audit | Tendering for goods and services – Estates Department                                                                  | 2018/19 | N/A | High   | Declarations of Interest                                             | The Director of Estates and Facilities, supported by the Office of the Board Secretary, identifies all posts which interact directly with suppliers and ensure annual declarations of interest are completed.                                                                                                                                                                                                                                                     | The Director of Estates and Facilities supported by the Office of the Board Secretary will confirm all identified posts within Operational Estates which interact with Suppliers and must therefore complete an annual Declarations of Interest return.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/03/2019 |            | 0 | 26/02/2019 | Closed - Verified     | A schedule has now been completed which identifies all Operational Estates Staff and Posts which are required to complete an Annual Declarations of Interest return commencing in April (2019/2020). This schedule has been shared with the Office of the Board Secretary who have overall responsibility for the management of the Register. A copy of the schedule is attached for information. |
| 750  | Internal Audit | Tendering for goods and services – Estates Department                                                                  | 2018/19 | N/A | High   | Pre-order Verification                                               | The Director of Estates and Facilities, using the Estates Operational Business Support Unit and GRAMMS functionality, ensures pre-order verification is undertaken independently of the three operational areas to ensure evidence of three quotations is present and have been obtained prior to the order being approved and issued.                                                                                                                            | The Director of Estates and Facilities through the Interim Head of Operational Estates will implement the following procedural changes through Operational Estates works management system (Gramms):- The Gramms works management system has an inbuilt facility for a designated user to “pre-authorise” an order prior to it being authorised by an approved signatory/budget holder. This pre-authorisation function will be transferred from the current locality based process based in East/Centre and West to the recently established centralised Operational Estates Business Support Unit. Additional validation checks will be incorporated at the pre-authorisation stage to ensure that potential multiple orders to the same supplier are not being raised on the same day or within the same week and that all procurement is in compliance with the Health Board's SFIs, Estates and Facilities Operational Scheme of Reservation and Delegation of Powers and Operational Estates Quotation Procedure. Additional functionality will be developed within the Gramms works management system to allow supporting documentation (quotation tracking sheet, copies of quotations/tender) to be uploaded and attached to an order to evidence compliance with Health Board procurement procedures and SFIs. Operational Estates Business Support Unit will undertake validation checks to ensure compliance. | 01/04/2019 |            | 0 | 25/04/2019 | Closed - Verified     | The second action contained within recommendation ISS.3, which includes functionality to upload tender documentation within GRAMS has now been complete and the system is live. A copy of the functionality pages is attached                                                                                                                                                                     |
| 751  | Internal Audit | Tendering for goods and services – Estates Department                                                                  | 2018/19 | N/A | High   | Operational management scrutiny                                      | The Director of Estates and Facilities, through the Head of Operational Estates (Acting): Ensures management reports are routinely run and reviewed to identify, for example, issues such as high volume orders/value by supplier; Orders raised on the same day to the same supplier etc. Uses the monthly senior management team meeting to openly scrutinise reports with the Procurement and Finance colleagues present.                                      | The Director of Estates and Facilities through the Interim Head of Operational Estates will strengthen the current management reporting arrangements as follows:- Operational Estates, as part of Estates and Facilities Divisional reporting structure hold monthly Finance meetings which are chaired by the Head of Operational Estates. In attendance are Estates Operations Managers (East/Centre & West, the Divisional Management Accountant and Capital Accountant from Finance and a Senior Procurement Officer from NWSSP. Activity reports will be presented to the Operational Estates Finance meeting to enable additional scrutiny and governance in regards to procurement and financial compliance. The activity reports will include details on procurement by supplier with the following aspects being reported - number of orders raised, average values, total expenditure within period and monitoring of quotations compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/01/2019 |            | 0 | 01/01/2019 | Closed - Verified     | Finding ISS.4 has now been completed and evidence has been submitted                                                                                                                                                                                                                                                                                                                              |



|      |                |                                                       |         |     |        |                                               |                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |            |            |   |            |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| 752  | Internal Audit | Tendering for goods and services – Estates Department | 2018/19 | N/A | Medium | Framework contract delivering value for money | The Director of Estates and Facilities, supported by Procurement and Finance officers, considers the introduction of framework contracts across the Health Board.                                                                                                                     | The Director of Estates and Facilities with support from the Interim Head of Operational Estates, Procurement Lead (NWSSP) and Finance Lead will establish a task and finish group to evaluate options for procuring a framework contract across the Health Board based on current service need. This evaluation will take into consideration current procurement directives pan Wales in regards to the extension of Welsh Governments Design for Life Framework.                                                                                                                                                                                                                                                                                                                                                                                                       | 30/04/2019 | 25/05/2019 | 1 | 29/05/2019 | Closed - Verified | The Task and Finish Group established to action Recommendation ISS.5 has now completed the work streams as defined within the ToR. The group met on the 20th of May and agreed the following Implementation plan :- 1- Work Stream 1 - Identify Local and National Frameworks available to the Division have been identified and recorded by NWSSP 2- Work Stream 2 - A detailed analysis of work undertaken by Operational Estates has been completed by activity,volume and category outputs from which will be utilised to inform procurement through NWSSP. 3 - Work Stream 3 - Current Tendering and Quotation procedures have been update by Monthly and Annual Procurement Reports which enables rotation of suppliers to be reviewed. All actions within the work streams have been completed and the Task and Finish Group has been stood down. |
| 753  | Internal Audit | Tendering for goods and services – Estates Department | 2018/19 | N/A | High   | Financial governance                          | A formal review of the governance and accountability arrangements is undertaken of both areas identified in this review as a matter of urgency.                                                                                                                                       | A review of the ordering process and associated governance system will be undertaken in collaboration with Procurement and Estates & Facilities.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/01/2019 |            | 0 | 22/02/2019 | Closed - Verified | The process has been reviewed and the examples found in the audit are considered to be one off examples due to staffing pressures within the Procurement Department. All staff involved in with the ordering of goods from a STW have been reminded of the process that must be followed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1081 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Funding Options                               | Options to resolve the funding deficit will be identified and resolved.                                                                                                                                                                                                               | Agreed. The Health Board has initiated an assessment of options to reduce the funding deficit, including revisions to scope and specification, as well as a review of the total budget and potential alternative funding sources. This assessment will reflect the balance of risk to the Board's priorities under its discretionary programme arising from the commitment to the YGC scheme. The resulting amendments to finance and programme will be formalised through the existing contract structure.                                                                                                                                                                                                                                                                                                                                                              | 30/09/2017 | 02/04/2018 | 2 | 28/03/2018 | Closed - Verified | Funding strategy to complete the project has been agreed, comprising: 1. Savings identified in equipment, works and contingency budgets. 2. Additional discretionary funding approved. 3. Brokerage and repayment arrangements agreed with Welsh Government.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 1082 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | SES Cost reporting review                     | The UHB will report these issues to NWSSP: SES for wider consideration.                                                                                                                                                                                                               | Agreed. Amendments to reporting requirements will be discussed and shared with NWSSP-SES.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31/07/2017 |            |   | 26/10/2017 | Closed - Verified | Amendments to reporting requirements discussed and shared with NWSSP-SES.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1083 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | Medium | Time v cost matrix                            | Future cost reports will include matrices of cost expended to date and time elapsed.                                                                                                                                                                                                  | Agreed. Future reports will include cross referencing of cost and time elapsed, noting the finding above that this is not a linear relationship due to the nature of the programme in YGC. Similar reporting requirements will be introduced for other major capital schemes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 30/09/2017 |            |   | 26/10/2017 | Closed - Verified | The adopted revised cost report format is now in operation and includes matrices identifying cost and time elapsed which will be used by project boards to challenge contingency usage and levels as well as to provide assurance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1084 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Thematic / causal analysis                    | Future projects will ensure that causal (thematic) analysis of contact changes is provided to an appropriate forum.                                                                                                                                                                   | Agreed. This will be introduced for the remainder of the YGC scheme as well as for other major capital schemes across the Health Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 31/08/2017 |            |   | 26/10/2017 | Closed - Verified | In providing cost advice and reporting to Project Boards and others as appropriate, Cost Advisors have been instructed, from July 2017, to provide causal (thematic) analysis of contract changes. This is included in the revised reporting framework.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 1085 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | CE Origin                                     | Appropriate causal commentary will be included with Compensation Event submissions to inform scrutiny and strengthen approval mechanisms.                                                                                                                                             | Agreed. Control documentation will be reviewed to ensure appropriate levels of analysis – see response to recommendation 4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/09/2017 |            |   | 26/10/2017 | Closed - Verified | Control documents for PMIs and CEs have been reviewed to incorporate details of thematic cause. Funding source is identified on all CEs and PMIs approved by the Project Director. In providing cost advice and reporting to Project Boards and others as appropriate, Cost Advisors have been instructed, from July 2017, to provide causal (thematic) analysis of contract changes. This is included in the revised reporting framework.                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1086 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Risk c continegncy                            | Effective risk management will validate and reconcile the client contingency requirement at key milestones.                                                                                                                                                                           | Agreed. Contingency assessment will be reported routinely under the revised reporting framework. See recommendation 9. Key milestones will be defined for the remaining lifetime of the project and formal contingency assessment will be undertaken at these points.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/08/2017 | 05/11/2018 | 2 | 06/11/2018 | Closed - Verified | Further milestone review undertaken on completion of asbestos removal. Risks to completion reviewed and out turn cost amended to reflect revised risk profile. Final cost now expected to be significantly below previous assessment of out turn.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1087 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Application of provisional sums               | Cost reports will be enhanced to detail the application of all provisions (including provisional sums).                                                                                                                                                                               | The NEC form of contract allows for the inclusion of a SCP risk allowance. This is for SCP related pricing and any programme risks to the SCP associated with this. This allowance is not contractually permitted to be utilised to support client changes but its utilisation will, in part, determine any future gain share. All client provisions and contingencies will be fully reported in accordance with the response to recommendation 14 above. The Board ' s appointed Project Manager has a duty to ensure that only matters relating to client changes are considered for charges against these sums. Use of the SCP risk allowance will be reviewed as part of the assessment of the defined cost of the works which will determine any gain share at the end of the project.                                                                              | 31/08/2017 |            |   | 26/10/2017 | Closed - Verified | Revised cost reporting format provides for monthly assessment and reporting of all client provisions and contingencies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1091 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Scheme of delegation                          | The functioning of the scheme of delegation will be reviewed to ensure on-going effective project management and appropriate compliance.                                                                                                                                              | Agreed. Control documents for compensation Events and PMIs will be reviewed to ensure that there is sufficeient analysis of cause and funding source. The scheme of delegation will be reviewed in light of the revised programme limits and compliance will be reviewed on an on-going basis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30/09/2017 |            |   | 26/10/2017 | Closed - Verified | Revised scheme of delegation in development incorporating all Client contingency provisions (see also recommendation 15). This was agreed by the Project Board in September 2017.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1092 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Key Risks                                     | Key risks will be explicitly considered and determined when major contract addition proposals are evaluated and approved.                                                                                                                                                             | Agreed. Key risks will be identified and documented as part of the agreement to the revised financing and programme determined by the Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/08/2018 | 02/04/2018 | 2 | 08/01/2018 | Closed - Verified | Risks documented as part of revised out-turn exercise.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1093 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | Medium | Adviser performance                           | Management will comply with national framework requirements to submit regular performance returns                                                                                                                                                                                     | Agreed. Performance returns will be submitted in line with national requirements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/07/2017 |            |   | 26/10/2017 | Closed - Verified | The latest national framework return was submitted at the end of September 2017 in line with national requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1094 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | Medium | Adviser roles                                 | A. Key adviser roles at the project will be independently reviewed. B. Advice will be obtained on enhancing the cost adviser role provided at this project (potentially this may include, for example, a third party attending the project board and vetting cost outputs/agreements) | The Health Board will seek legal advice and an external assessment of performance of the Cost Adviser function under this project.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/07/2017 | 28/09/2018 | 5 | 01/10/2018 | Closed - Verified | Report received by F+P committee on 25th September 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 1095 | Internal Audit | Ysbyty Glan Clwyd                                     | 2015/16 | N/A | High   | Cost reporting                                | The Cost Adviser will be requested to review the deficiencies identified and address at future reports                                                                                                                                                                                | Agreed. The format of future cost reports is being reviewed by the Health Board. A revised reporting framework will be issued to Cost Advisers on all major projects, including YGC. Amendments to reporting requirements will be discussed and shared with NWSSP-SES.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/07/2017 |            |   | 26/10/2017 | Closed - Verified | Revised reporting format agreed and adopted addressing identified deficiencies from July 2017 for all major projects. New format utilised for cost reporting to the YGC project board in August.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 1097 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre       | 2016/17 | N/A | Medium | Causality of AI costs                         | Following assessment of Architect Instruction's time and cost implications, reporting will distinguish causality of time and cost increases between contractor and client.                                                                                                            | Agreed. Recommendation 4 and 6 appear to be similar. As noted for recommendation 4 whilst we acknowledge that the cost and time implications of AI's had not been fully agreed an assessment of the impact had been reported to the Health Board. The PM has instructed the CA and Contractor to ensure all AI's are now assessed for cost and programme implications. The delay to the programme and potential increase in cost was first reported to the Assistant Director of Strategy via the month 5 Highlight report. This was in turn reported to the Finance and Performance committee and Welsh Government. Following clarification of the potential additional cost, and a review of VE opportunities, the delay, cost and impact on contingency were reported in month 7 to the Assistant Director of Strategy and again in turn to the F&P committee and WG. | 30/06/2017 |            |   | 26/10/2017 | Closed - Verified | The Health Board has implemented a revised cost reporting template that includes for all known and anticipated / pending instructions with provision made to include associated cost and time implications.The report clarifies the liability with respect to the Health Board or Contractor and the impact upon the Health Boards provision for risk.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1098 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre       | 2016/17 | N/A | Medium | Phased Benefits Plan                          | The UHB will develop an appropriately phased benefits realisation plan                                                                                                                                                                                                                | Noted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 30/06/2017 |            |   | 02/11/2017 | Closed - Verified | The Project Board has agreed the Benefits Realisation Plan as the business case.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|      |                |                                                 |         |     |        |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |            |            |   |            |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| 1099 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre | 2016/17 | N/A | Medium | Timely contracts                                           | Contracts will be appropriated executed in a timely manner (in accordance with the UHBs 'Procedure Manual for Managing Capital Projects' guidance). . (O)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | We note the delay in the completion of the contract documents. It should be noted that an Award letter was issued to the contractor prior to commencement on site that confirmed acceptance of their tender, and by implication the "contractors offer" therein, the contract sum and the form of contract. The risk to the Health Board was therefore mitigated to a large extent as the terms and conditions had been defined. However, we accept that it is good practice to ensure that contracts are executed in a timely manner and the HB are now actively reviewing and monitoring the completion of contract documents. Furthermore, letters of intent are now required to be limited in terms of value, time and scope and signed by the Chief Executive.                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 30/06/2017 |            |   | 26/10/2017 | Closed - Verified | This audit recommendation has been embedded within the Health Boards Procedure Manual. Letters of Intent are permitted subject to scope, time and value constraints and must be monitored by the relevant Project Board.                                                                                                                                                                                                                                                                               |
| 1101 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre | 2016/17 | N/A | Medium | Project Execution Plan                                     | Project Execution Plans of appropriate content (to the size and complexity of scheme) will be applied as a dynamic project control document in accordance with the University Health Board's capital procedures.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Agreed. We note the delay in the preparation of the PEP. For future schemes the PEP will be developed in accordance with the requirements of the manual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18/04/2018 |            |   | 26/10/2017 | Closed - Verified | The Health Boards Procedural Manual defines the requirement for Project Execution Plans subject to value and complexity of the project.                                                                                                                                                                                                                                                                                                                                                                |
| 1102 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre | 2016/17 | N/A | Medium | Costed AI's                                                | All Architect Instructions will include associated time and cost implications in accordance with contractual requirements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Whilst we acknowledge that the cost and time implications of AIs had not been fully agreed an assessment of the impact had been reported to the Health Board. The PM has instructed the CA and Contractor to ensure all AI's are now assessed for cost and programme implications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/05/2017 |            |   | 26/10/2017 | Closed - Verified | The monthly Cost Reports include for known and anticipated / pending instructions and provision made to include associated cost and time implications. The Cost Advisor and Contractor meet regularly to progress the Final Account. It should be noted that in accordance with the terms and conditions of the contract, in this instance JCT, the Contractor's contractual obligations require him to provide all information relating to the final account within 6 months of Practical Completion. |
| 1103 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | High   | Partnership working - Formalising contractual arrangements | The Health Board ensures all new implementation projects where the supplier is within NHS Wales, are the subject of a formal contract or service level agreement that has been developed and signed by both parties; This will ensure the NHS Wales supplier is held to account for delivery and associated costs attributed to any delay.                                                                                                                                                                                                                                                                                                                                                                                   | We will establish more formal arrangements for the implementation of Projects where the supplier is within NHS Wales. In the longer term we will seek to define these on an all Wales Basis by working with all relevant stakeholders (Other Health Boards and NWIS). The Assistant Director of Informatics will follow up on initial discussions relating to this matter, by formally writing to the Director of Finance and Business Assurance for NWIS. This letter will provide a mandate for this work and outline required timescales for agreement of arrangements. In the shorter term we will we will:- Ensure that all of the deliverables are clearly established within the PID which is approved by the supplier (amongst others) Gain formal approval of the PID from the Programme Board, evidencing appropriate consultation and agreement on content Formally review the performance of the supplier at board meetings against agreed criteria on a regular basis (defined within cycle of business). Take corrective actions as required Review all other "NHS supplier" projects being undertaken, risk assess and prioritise work required to establish formal service level agreements with these. | 01/06/2018 |            | 0 | 28/11/2017 | Closed - Verified | Formal SLA talks commenced. Have achieved some reduction in SLA costs this year and have formalised negotiation for next year. The principles regarding formalised agreements for delivery of national systems has been agreed and will be applied in all future schemes.                                                                                                                                                                                                                              |
| 1104 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | High   | Governance structure, approvals, reporting and meetings    | The requirements of the Office of the Board Secretary underpin the project structure, ensuring decisions taken are formalised, minuted as such, and can be followed at every juncture. All TOR should be approved by the meeting to which assurance is provided. The structure and governance for the project is reviewed and membership of the PB and project team for further implementation stages ensures the right officers are identified and made available to attend. Consideration is given that the Chair (Senior Responsible Officer) is the lead Executive Director, as delegated by the Chief Executive Officer (Accountable Officer) akin to other capital projects currently running across the Health Board. | We will ensure that the guidance of the office of the board secretary is followed. To do this we will assess training requirements for Project staff and put in place training packages where required to ensure that appropriate governance is in place and evidenced. Review the structure and governance of the Programme, ensure stakeholder representation is clearly identified and that responsibilities are understood. These will be clearly articulated in a Project Initiation Document (PID) which will be drafted by the Programme Manager and formally approved by the Programme Board The current chair of the board to review with SRO and Board Secretary. Internal Audit to reassess compliance and progress in this area.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 30/09/2017 | 25/04/2018 | 6 | 16/04/2018 | Closed - Verified | Revised TOR is part of the Agenda for April 2018 WPAS Programme board for final sign-off. The agenda and minutes from April onwards follow the office of the board secretary templates. I've attached the agenda for April and the TOR to be approved. The April minutes are available on request one week after the board.                                                                                                                                                                            |
| 1105 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | Medium | Dependencies                                               | The Project Board ensures all interdependencies are brought to its attention which could impact on the timely implementation of the remaining stages of the project e.g. WCCIS etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | During 2017 a new governance structure is being introduced which will include a Digital Transformation Group (DTG) that will oversee the prioritisation of competing informatics projects ensure a clear portfolio approach to managing interdependencies. Project Managers will ensure that interdependencies are clearly identified within project risk registers and on project plans and that these are subject to appropriate management, monitoring and checks. These will be discussed (agenda items) in project boards, where impacts on actual projects can be assessed. Escalation procedures to the Digital Transformation Group will be clearly defined within the expected range of project documentation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30/09/2017 |            | 0 | 05/10/2017 | Closed - Verified | Project interdependencies clearly identified and understood formally as part of the programme.                                                                                                                                                                                                                                                                                                                                                                                                         |
| 1106 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | Medium | Management of project risk                                 | The Project Board formally consider the Project Risk Management Strategy, and ensure sufficient scrutiny is applied to the risk register and that this is evident and explicit in demonstrating that assurance is sought that the risks are being effectively managed.                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A Risk management strategy which details:- The objectives of risk management Processes e.g. how the project will lead, direct and control risks relating to the project through the project life cycle Job holders with responsibilities in the management of risk will be submitted to the project board for consideration and approval. Risk identification and review will be a standard and documented agenda item in all project meetings. Whilst all risks will be available to the Project Board, all red risks will be presented at meetings and all "escalated risks" from the project team (representative of all stakeholders) will be discussed in detail.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30/09/2017 | 25/04/2018 | 4 | 16/04/2018 | Closed - Verified | The Project Board have formally considered the Project Risk Management Strategy at the March WPAS Programme board. Following a few sections that require revision the final paper is expected to be signed off at the April board. The risk management strategy has been attached for information and the board minutes are available if needed.                                                                                                                                                       |
| 1107 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | Medium | Budgetary implications of WPAS                             | The Health Board formally writes, challenging the pricing structure for WPAS as assigned to the Health Board, as it cannot demonstrate value for money with a 159% service charge increase from 2017/18 onwards.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | The Health Board has challenged and continues to challenge the pricing structure with NWIS for the range of services and products that it supplies. Concerns have been raised with the Director of Finance within NWIS and discussions have been held at all Wales Assistant Director of Informatics meetings particularly relating to equity of pricing. In the longer term, we will seek to define pricing structures on an all Wales Basis by working with all relevant stakeholders (Other Health Boards and NWIS). In the shorter term the Assistant Director of Informatics will follow up on initial discussions relating to this matter by formally writing to the Director of Finance and Business Assurance for NWIS. This will provide a mandate for this work and outline required timescales for agreement of arrangements. The need to evidence value for money will be clearly articulated. (Ref to response ISS1 for additional detail)                                                                                                                                                                                                                                                                 | 01/06/2018 |            | 0 | 28/11/2017 | Closed - Verified | WPAS Service charged reduced for this year - negotiation re next year underway but will also depend on WPAS rollout phasing                                                                                                                                                                                                                                                                                                                                                                            |
| 1108 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | High   | Quality Plan and Register                                  | The Quality Plan and Quality Plan register are considered by the Project Board for accuracy, expected success criteria etc and then reported on a regular basis for assurance purposes - This should be factored in to the Board cycle of business                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | The Quality Plan will be reviewed by the Programme Board (now that we are entering a new phase and project board membership has changed) and approval will be sought. This will be clearly documented. High-level quality criteria will be outlined within the PID as project objectives; these will be monitored throughout the lifecycle of the project as part of the boards' cycle of business. A clear link between these and go live criteria will be made.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 30/09/2017 |            | 0 | 19/09/2017 | Closed - Verified | All future large projects will ensure that the Quality register is an regular agenda item with changes highlighted and approved by the relevant boards.                                                                                                                                                                                                                                                                                                                                                |
| 1109 | Internal Audit | Welsh Patient Administration System (WPAS)      | 2016/17 | N/A | High   | Service continuity                                         | For the remaining steps for implementing the project in the West and East area, a full dress rehearsal with full user acceptance testing should be applied to ensure the system is fit for purpose prior to an agreed 'go-live' date.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Go live criteria for WPAS (and other Projects) will be updated following lessons learnt from WPAS central. This will include a requirement (defined within project plans) to undertake a "full dress rehearsal". Go live criteria will be based on "hard" evidence of progress against objectives and criteria only. This will enable evidence based decisions to be made.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/09/2017 |            | 0 | 19/09/2017 | Closed - Verified | Generic Project data migration project templates have been updated to include the requirement for a full dress rehearsal with the associated key operational staff involved and plans to include a system switch off to enact business continuity plans for a weekend thus creating a realistic go-live environment                                                                                                                                                                                    |
| 1110 | Internal Audit | Ysbyty Gwynedd A&E                              | 2017/18 | N/A | Medium | Attendance at Project Implementation Board                 | The attendance rates of the core members of the Project Implementation Board will be monitored and reported on an on-going basis (and appropriate action taken in the event of consistent non-attendance). Membership of the Project Implementation Board will be evaluated at key project stages to ensure its appropriateness                                                                                                                                                                                                                                                                                                                                                                                              | Actions to be implemented by Project Director as confirmed by Assistant Director of Strategy Capital in email dated 21st August 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28/09/2018 |            | 0 | 25/02/2019 | Closed - Verified | Representation issues have been addressed and an improvement in core members seen. This action is monitored monthly and addressed as any further issues arise.                                                                                                                                                                                                                                                                                                                                         |
| 1111 | Internal Audit | Ysbyty Gwynedd A&E                              | 2017/18 | N/A | Low    | Project Director                                           | The role of Project Director should be formally assigned and accepted utilising the Project Director appointment letter/certificate or similar (See appendix C for example).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Agreed with Assistant Director of Strategy Capital in email dated 21st August 2018                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 30/11/2018 |            | 0 | 18/10/2019 | Closed - Verified | NWSSP Specialist Audit Service - follow up audit of October 2019 confirms that this recommendation has been closed.                                                                                                                                                                                                                                                                                                                                                                                    |

|      |                |                                                                                                                                           |         |     |        |                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |            |   |            |                              |                                                                                                                                                                                                                                                                                         |
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| 1112 | Internal Audit | Ysbyty Gwynedd A&E                                                                                                                        | 2017/18 | N/A | Low    | Project Director                                                                                                                          | The UHB's Capital Procedures Manual will be updated to include the requirement for a Project Director's Acceptance Certificate/letter of appointment                                                                                                                                                                                                                                                    | Agreed with Assistant Director of Strategy Capital in email dated 21st August 2018                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/11/2018 |            | 0 | 18/10/2019 | Closed - Verified            | NWSSP Specialist Audit Service - follow up audit of October 2019 confirms that this recommendation has been closed.                                                                                                                                                                     |
| 1114 | Internal Audit | Ysbyty Gwynedd A&E                                                                                                                        | 2017/18 | N/A | High   | Supply Chain Partner- Financial Stability                                                                                                 | The UHB should monitor financial health of the SCP (ensuring current and on-going advice is appropriately received).                                                                                                                                                                                                                                                                                    | Accepted - In common with other Health Boards, BCUHB receive periodic reports from NWSSP SES with respect to the financial health of Interserve.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28/09/2018 |            |   | 22/11/2018 | Closed - Verified            | Please see attached reports. The Health Board receive regular reports as evidenced.                                                                                                                                                                                                     |
| 1118 | Internal Audit | Ysbyty Gwynedd A&E                                                                                                                        | 2017/18 | N/A | Low    | KPI Reporting                                                                                                                             | The UHB will ensure that KPI returns are made promptly (in accordance with the and in Designed for Life: Building for Wales framework requirements).                                                                                                                                                                                                                                                    | Agreed with Assistant Director of Strategy Capital in email dated 21st August 2018                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/11/2018 |            |   | 28/11/2018 | Closed - Verified            | KPIs completed in September in accordance with national policy                                                                                                                                                                                                                          |
| 667  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 1 - Post contract audit of costs                                                                                           | Where 'contractual' terms allow, a detailed post contract audit of costs must be undertaken. [To be undertaken as soon as practicable]                                                                                                                                                                                                                                                                  | The Health Boards occupation is regulated through a licence to occupy for a fixed period of three months then one-month notice on either party to terminate. This is a formally agree arrangement with all three property owners. The Health Board is currently concluding the evaluation of consequential losses in partnership with two Local Authorities (FCC & CCBC) and Bangor University. Conclusion of these consequential loss negotiations will be defined within a commercial agreement with all three parties to limit the Health Board exposure. The Health Board has instructed NHS Wales Shared Service - Legal & Risk to draft these terms following completion of the negotiations. There is only one externally provide FM contract in place at Ysbyty Enfys Deeside with Vinci plc. This will be reviewed post closure of the field hospital site. The two remaining FM providers are Landlord provided i.e LA and University. | 30/04/2021 |            | 0 | 02/06/2021 | Implemented - Audit Approved | Actions addressed                                                                                                                                                                                                                                                                       |
| 668  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 2 - Documentation reviewed and formalised where contractual relationships are not fixed                                    | Documentation to be reviewed and formalised where contractual relationships are not fixed. [To be undertaken as a priority]                                                                                                                                                                                                                                                                             | See R1 – covered by the Consequential losses commercial agreement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30/04/2021 |            | 0 | 02/06/2021 | Implemented - Audit Approved | Actions implments through Licence to Occupy                                                                                                                                                                                                                                             |
| 669  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 3 - Post contract cost audit exercise to be performed as part of project closure                                           | Post contract cost audit exercise to be performed as part of project closure. [To be undertaken prior to project formal closure]                                                                                                                                                                                                                                                                        | Internal Audit to undertake the review. Terms of Reference to be agreed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/04/2021 | 31/03/2022 | 3 | 23/02/2022 | Implemented - Audit Approved | Draft Report issued (assurance not applicable). See attached evidence, Rec complete.                                                                                                                                                                                                    |
| 670  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 4 - Updating of analysis, risk assumptions and dependencies as sites continue to be held, used or decommissioned           | Updating analysis, risk assumptions and dependencies as sites continue to be held, used or decommissioned needs to continue. [To be reviewed as part of on-going planning]                                                                                                                                                                                                                              | The capacity plan is set out in the Q3/Q4 plan supported by the Winter Resilience Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30/04/2021 | 31/03/2022 | 1 | 23/02/2022 | Implemented - Audit Approved | Internal Audit follow up review / report (issued 06/12/21) shows this rec as implemented                                                                                                                                                                                                |
| 671  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 5 - Capacity plan aligning beds, workforce, and financial impact, outlining how organisations would manage any risk        | Inherent uncertainty remains in future demand forecasts and challenges to staffing and recruitment. [These challenges need to be considered and aligned through a clear capacity plan aligning beds, workforce, and financial impact, with the narrative plan outlining how organisations would manage any risk and flex in that position pending impact of COVID.]                                     | The capacity plan is set out in the Q3/Q4 plan supported by the Winter Resilience Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30/04/2021 | 04/01/2022 | 3 | 16/02/2022 | Implemented - Audit Approved | Dealt with within IMTP                                                                                                                                                                                                                                                                  |
| 672  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 6 - Monitoring of reinstatement costs for reasonableness and tracking to ensure clawback of any unused or misapplied funds | Health Boards must proactively monitor reinstatement costs for reasonableness (avoiding betterment) and ensure there is appropriate tracking to ensure clawback of any unused or misapplied funds. [To be undertaken as part of the due diligence on the return of Field Hospital sites – but clarity around the approach to be taken needs to be provided to WG]                                       | Specification for reinstatement to be agreed in advance between BCU and landlord including agreement of betterment and appropriate funding. Cost Advisors to monitor reinstatement costs and provide regular report to BCU confirming expected out turn cost and identifying any variations that may be determined as further betterment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/07/2021 |            | 0 | 26/07/2021 | Implemented - Audit Approved | Specification of reinstatment works finalised together with details of "betterment". Cost and funding of "betterment" agreed with relevant landlord.                                                                                                                                    |
| 673  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 7 - Approach to consequential losses considered and managed in line with rules impacting on future use of facilities       | Similar to the reinstatement costs, the approach to consequential losses must be considered and managed carefully by each Health Board in line with rules and conditions impacting on any future use of the facilities. [Health Boards to provide detail as to how they are approaching consequential losses]                                                                                           | Paper on approach to the agreement of Consequential Losses submitted to Audit Committee. Paper outlines the governance behind any such payment and the authorisation process for payments, which reflects the SFIs and Manual for Accounts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/07/2021 |            | 0 | 06/08/2021 | Implemented - Audit Approved | paper submitted to Audit Committee on approach to Consequential Losses                                                                                                                                                                                                                  |
| 674  | Internal Audit | Temporary Hospitals: Follow-up of KPMG recommendations                                                                                    | 2021    | N/A | High   | Recommendation 8 - Emergent issues linked to decommissioning and consequential losses to be monitored                                     | Emergent issues linked to decommissioning and consequential loses must be carefully monitored particularly in respect of funding arrangements and timing of requirements. [Health Boards to provide WG with the latest estimates (and approaches taken in calculating this)].                                                                                                                           | Decommissioning will be either a settlement valuation agreed by both parties ie the HB would pay a value to reinstate, but not be obliged to undertake the work. Probably the case for Deeside and Bangor. Venue Cymru will want Health to fully reinstate.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/07/2021 |            | 0 | 06/08/2021 | Implemented - Audit Approved | Estimate of Consequential Losses submitted to Welsh Government as part of 2020-21 Accounts. Reinstatement costs are on - going                                                                                                                                                          |
| 724  | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | High   | Reporting arrangements and assurance                                                                                                      | The governance and assurance reporting arrangements relating to catering, nutrition and hydration are reviewed as soon as possible [including associated terms of reference/minutes/membership], ensuring it has the right structure and accountability in situ to deliver its responsibilities for meeting Health & Care Standard 2.5 and the recommendations in the Public Accounts Committee report. | The reporting structure for INCHS will be directly to the Quality and Safety Group (QSG) for the Health Board and this will be reflected in the Terms of Reference (TOR) for INCHS. The INCHS amended TOR will be reviewed at the next quarterly meeting on the 7th December 2018. Reporting arrangement for FINCH and the ANG will be reviewed at that meeting and the TOR will be reviewed following that. A new Board champion for nutrition will need to be identified as the previous representative has moved on to the position of vice Chair of the Health Board. Steven Grayston will pick that up directly with the previous incumbent.                                                                                                                                                                                                                                                                                                | 31/01/2019 |            | 0 | 12/02/2019 | Implemented - Audit Approved | The terms of reference for the group have been updated and reviewed with a change of reporting arrangements directly to QSG now. They have been put into the corporate format, which was recommended by the audit team.                                                                 |
| 754  | Internal Audit | Welsh Risk Pool - Claims Management Standard                                                                                              | 2019/20 | N/A | Medium | Datix Information                                                                                                                         | Claims managers must ensure that all relevant fields within Datix are completed comprehensively, accurately, and in a timely manner.                                                                                                                                                                                                                                                                    | Claims managers have been made aware of the audit findings. The section on Datix to record LFER data was reviewed in December 2019 and changes have been made to the system in March 2020; this covers both interim and final payments and learning only submissions and well as reimbursement submission. A monthly review will be undertaken for the next six months to check dates have been entered correctly with any anomalies flagged to reinforce recording.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01/10/2020 | 30/11/2020 | 1 | 26/10/2020 | Implemented - Audit Approved | We have undertaken a “snap shot” review of Clinical Negligence and Personal Injury Claims, looking at a sample from April – September 2020. 19 case files on the Datix management system were reviewed, each of the Data fields were reviewed. All fields were completed appropriately. |
| 769  | Internal Audit | Budget Setting                                                                                                                            | 2019/20 | N/A | Medium | Appendix Reconciliation Docs                                                                                                              | Whilst recognising that budgets are subject to several revisions over the course of the budget setting period, Finance management must ensure that all final reconciliation documentation and appendices are completed and retained.                                                                                                                                                                    | Noted. Whilst the only formal Appendix A submitted (summary of forecast outturn and underlying deficit) was based on M07 data, the movement in forecast outturn between M07 and the position in the final budget proposals to the Health Board which was based on M9 data, was £111,000. In future CFOs will be requested to submit an updated Appendix A updated to reflect the Health Board's final budget proposals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13/11/2020 |            | 0 | 23/11/2020 | Implemented - Audit Approved | complete                                                                                                                                                                                                                                                                                |
| 770  | Internal Audit | Budget Setting                                                                                                                            | 2019/20 | N/A | Medium | Prophix costfings                                                                                                                         | To maintain a robust audit trail for future budget setting, managers should retain copies of all key data sources and reports that inform the opening budget position                                                                                                                                                                                                                                   | Agreed. A Prophix data files download showing the detailed calculations for the final budget will be run and retained. The systems notes will be updated to ensure this is always undertaken for future periods.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 13/11/2020 |            | 0 | 23/11/2020 | Implemented - Audit Approved | Complete                                                                                                                                                                                                                                                                                |



|     |                |                                                      |         |     |        |                              |                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |            |   |            |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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| 789 | Internal Audit | Managed General Practitioner Practices               | 2019/20 | N/A | Medium | New Recommendation           | Area Management Teams finalise the KPIs for all Managed Practices as soon as possible.                                                                                                                                                                                                                                                                   | A standard set of KPIs are in place for managed practices and amendments and changes to these has been the responsibility of the North Wales Governance of Managed Practices Group to date but will move with the hosting arrangements as set out above. In terms of current KPIs all areas will report to their finance and performance committees (or equivalent) with immediate effect. Since the completion of the draft audit documentation, Central Area has provided performance management information. An Area Managed Practice Operational Group is in place and is well established. This is chaired by the Assistant Area Director Primary Care, and the Head of Service and practice managers attend. Performance delivery is reviewed in these meetings and is included in the Terms of Reference of the group. In addition, each division within the Area provides monthly performance reports to the Area Leadership Team; for primary care this includes a report on managed practices. The Head of Service has been developing the local KPI report with each practice and work was ongoing with informatics colleagues to develop an overarching dashboard. Central Area are also represented on the North Wales Managed Practice Governance & Accountability group.                                                                                                                                                                                                       | 13/11/2020 |            | 0 | 07/12/2020 | Implemented - Audit Approved | An agreed set of KPIs for managed practices are in place and are reported at Area level within their governance structures.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 804 | Internal Audit | Ysbyty Gwynedd Emergency Department Patient Monitors | 2019/20 | N/A | High   | Controls over loan equipment | Secondary Care Management, in conjunction with Procurement and EBME colleagues, ensure the process in situ for managing trial/use of loan medical equipment/consumables are subject to review ensuring robust clinical governance processes.                                                                                                             | The Head of Procurement has contacted all his peers elsewhere in Wales to ascertain what, if any policies exist in relation to trials. BCUs EBME manager has been approached and has agreed to work with the Head of Procurement (HoP) to draft a trials policy. It is intended that the first draft document be tabled at July's Procure to Pay group to obtain finance support prior to BCU pursuing its own governance arrangements in terms consultation, approval and cascade. Trials are also closely linked to managing Supplier representatives, similarly a potential area for improvement as Procurement aren't aware of a specific HB policy. Attached is the All Wales Supplier Policy (APPENDIX D) which could be tailored to meet the needs of the HB. The HoP has tabled a potential 'solution' which had become apparent following the wider trials discussions on discovering that this option is used elsewhere in NHS Wales. The subject of an electronic solution was discussed as June's Procure to Pay group and is currently being reviewed by finance colleagues. This system is appointment based, and provides visibility to both HB and Procurement of all supplier representatives on site, the purpose of their meetings and with whom they are engaging. Additionally the HoP suggests that the current Budget Managers Handbook is updated by the HB and that section 4.4 includes statement in relation to how to manage trials and supplier representatives. | 31/01/2020 | 31/10/2020 | 2 | 07/12/2020 | Implemented - Audit Approved | The assessment is that progress has been made as far as possible with these elements and therefore the recommendation should be closed with further consideration to be given as and when progress by Procurement/Finance in regard to their respective elements can be made.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 846 | Internal Audit | Mental Health Approved Clinicians - Governance       | 2021    | N/A | High   | Board Ratification           | Whilst recognising the potential impact on service delivery pertaining to delayed approvals Health Board must ensure current arrangements conform to legislative requirements. If Board timetable is not conducive to timely approval, the Approvals Team should seek Chair's Action in order to facilitate Chief Executive approval and notification.   | The All Wales Approvals Unit has discussed the matter with the Deputy Board Secretary and agreed to progress timely approvals via Chair's action as and when required, with the Deputy Board Secretary briefing the Chairman of the likely increase in Chairs action approvals. The regular report to the Board will continue to be presented but with the additional information confirming all cases that have been progressed via Chair's action.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10/05/2021 |            | 0 | 01/04/2021 | Implemented - Audit Approved | Use of the Chair's Action has now been implemented by the All Wales Approvals Team from 1st April 2021                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 848 | Internal Audit | Mental Health Approved Clinicians - Governance       | 2021    | N/A | Low    | Budgetary Accountability     | Management review whether the current budgetary delegation and accountability arrangement is appropriate and consistent with Health Board budgetary and financial management principles.                                                                                                                                                                 | Discussions continue with the Nurse Executive and Office of the Medical Director, aiming to ensure transfer of accountability of the ring fenced budget. Confirmation of source and purpose of funding to ensure that it is not linked to Deprivation of Liberties safeguarding is required to complete the transfer. This is in progress.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01/07/2021 |            | 0 | 10/06/2021 | Implemented - Audit Approved | Agreement has been made to transfer the budget from the Nurse Executive to the OMD. The transfer is currently being processed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 905 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R1                           | Developing a robust emergency plan pack for any future peaks of the pandemic, to allow a swift enacting of measures required.                                                                                                                                                                                                                            | There is no intention to stand up a command & control at present to manage any covid-19 second wave, this is to be managed through the established covid-19 unit. Executive responsibility for this rests with Executive Director of Primary Care & Communities. However, Strategy & Planning have completed a covid de-brief and identified a number of key recommendations (agreed and approved by the Executive team and by SPPH Committee). Recommendations include strengthening our major incident command and control framework and arrangements. Executive responsibility for developing the command and control framework development rests with the Executive Director of Planning & Performance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/12/2020 |            | 0 | 12/01/2021 | Implemented - Audit Approved | All plans have received approval at either Executive Team or via the Civil Contingencies Group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 906 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R10                          | Consider the continued use of virtual meetings and supporting arrangements, within the Committee structure.                                                                                                                                                                                                                                              | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/12/2020 |            | 0 | 10/03/2021 | Implemented - Audit Approved | Use of virtual meetings platform continues with move to Zoom for public Board to facilitate simultaneous translation whilst live streaming the meeting to YouTube. Virtual platforms continue to be used for all Committees. Action Complete. Recommend for closure..                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 907 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R2                           | All of the Executive Team undergo 'Gold' training which is refreshed in accordance with their personal development requirements.                                                                                                                                                                                                                         | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/12/2020 | 31/07/2021 | 2 | 01/09/2021 | Implemented - Audit Approved | Gold on-call training provided to newmembers of the executive team and other senior staff joining the rota. This will continue as and when required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 908 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R3                           | The Health Board Chair should not be required to Chair any operational groups.                                                                                                                                                                                                                                                                           | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/12/2020 |            | 0 | 10/03/2021 | Implemented - Audit Approved | Confirmed. Health Board Chair is no long required to Chair any operational groups.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 909 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R4                           | Establishing a clear Scheme of Reservation and Delegation and decision making framework, with approved Terms of Reference, that sets out which decisions (operational and strategic) require approval by which forum (e.g. Silver/Gold/Executive Team/Health Board) thus ensuring documentation is complete and maintained for each respective decision. | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/12/2020 |            | 0 | 10/03/2021 | Implemented - Audit Approved | Paper taken to Cabinet on 1st February 2021 which sets out the decision making arrangements through the established Executive Incident Management Team. The paper also included as an Appendix the structure of the Coronavirus Co-ordination Unit which provides a mechanism for oversight and effective tracking of Covid-19 decision making. A revised SORD has not been needed during this wave as EIMT is linking into routine governance and accountability mechanisms.                                                                                                                                                                                                                                                                                                                                                                                         |
| 910 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R5                           | Documenting all decisions taken in accordance with published guidance, with a clear audit trail.                                                                                                                                                                                                                                                         | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/12/2020 |            | 0 | 10/03/2021 | Implemented - Audit Approved | See report to Cabinet 1st February 2021 which sets out arrangements for the oversight and effective tracking of Covid-19 Decision making.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 911 | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High   | R6                           | Updating all business continuity plans throughout the Health Board, to reflect changes required as a result of the pandemic.                                                                                                                                                                                                                             | Accepted. All BCM plans will need to be updated to reflect our learning from, and take into account the covid pandemic. The Business Continuity Team will engage with all divisional leads to secure their commitment through our civil contingencies group governance arrangements and confirm realistic date for completion following this. This will be incorporated into our CCG work programme with progress reported through to SPPH committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/12/2020 | 31/12/2021 | 1 | 26/05/2021 | Implemented - Audit Approved | The Business Continuity Manager has liaised with all BC plan leads/owners. Business impact analysis and business continuity plans are now being developed taking into consideration the learning from Covid. Meetings have been held with divisional leads and training is also being provided by resilience team to ensure that the learning from Covid and any change to critical functions and practices adopted due to the pandemic are reflected within plans. All Business Continuity plans are being reviewed as part of our BCM work programme which is overseen by and progress reported to BCU Civil Contingencies Group. The current monitoring report highlights where plans are complete or being finalised / awaiting final approval. The responsibility for completion of plans is also clarified within the report at a service / departmental level, |

|      |                |                                                      |         |     |      |             |                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |            |            |   |            |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| 912  | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High | R7          | Ensure all COVID-19 risks are recorded in accordance with the Risk Management Strategy and migrate into day to day management now the Health Board has moved to business as usual.                                                                | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/12/2020 |            | 0 | 17/12/2020 | Implemented - Audit Approved | Revised Risk Management Strategy implemented on 1st October 2020. All Covid-19 risks are now captured in Datix (including PPE and Fit Testing). Review and oversight is taking place at RMG and Exec Team (see update attachments for evidence). Escalation of Covid-19 risks will come through to RMG and then up to the Exec Team for approval and inclusion onto the Tier 1 Corporate Risk Register, as per normal governance route and flow chart within the RM Strategy. Virtual agreement to escalate can be undertaken outside of any of the meetings as part of Chair's Actions. |
| 913  | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High | R8          | Reviewing insurance and indemnity arrangements to ensure adequate cover is in place for all additional sites established within the Health Board, e.g. Test, Trace, Protect testing sites                                                         | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/12/2020 | 31/03/2021 | 1 | 31/03/2021 | Implemented - Audit Approved | This recommendatoin has been clarified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 914  | Internal Audit | Governance Arrangements during the Covid-19 Pandemic | 2020    | N/A | High | R9          | Continue to ensure GDPR requirements are maintained, with the continued and increase of home working arrangements, including the use of personal equipment for work related activities (e.g. mobile phone to access Office 365 Teams and Outlook) | Accepted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/12/2020 | 30/04/2021 | 4 | 14/04/2021 | Implemented - Audit Approved | See attached documentation which is being implemented, just awaiting final sign off from Exec Nurse Business Meeting                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 1088 | Internal Audit | Ysbyty Glan Clwyd                                    | 2015/16 | N/A | High | SCP sign-up | Management will arrange an appropriate contractual formalisation of the SCP commitment to the revised financial forecast for the project.                                                                                                         | Agreed. The Health Board has initiated an assessment of options to reduce the funding deficit, including revisions to scope and specification, as well as a review of the total budget and potential alternative funding sources. This assessment will reflect the balance of risk to the Board's priorities under its discretionary programme arising from the commitment to the YGC scheme. The resulting amendments to finance and programme will be formalised through the existing contract structure. | 30/09/2017 | 29/03/2019 | 4 | 15/01/2019 | Implemented - Audit Approved | The expected out turn cost and gain share have been agreed with SCP subject only to final agreement of provisional allowances that cannot be fully confirmed until the works are complete. The formal deed of variation has been enacted in respect off the treatment of inflation. NWSSP-Specialist Services have confirmed that this recommendation is closed (email to N Bradshaw dated 15 January 2019).                                                                                                                                                                             |

TEAMMATE UPDATE PRE-2022  
APPENDIX 5 - INTERNAL AUDIT - ALL 'OTHER CATEGORIES'

Sorted by TeamMate category

| ID  | Internal Audit/<br>Audit Office | Report Title                                               | Year    | Assurance Level | Priority | Recommendation Title                                            | Recommendation                                                                                                                                                                                                                                                                                                                                                                                            | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Original implementation date | Revised implementation date | Number of Revisions | Actual Implementation Date | Date Final approved | TeamMate state                      | TeamMate system update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Audit Category                     | Audit Comment                    |
|-----|---------------------------------|------------------------------------------------------------|---------|-----------------|----------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|---------------------|----------------------------|---------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------|
| 483 | Internal Audit                  | Procurement: Contract Management and Single Tender Waivers | 2021    | Reasonable      | Medium   | Matter Arising 1: Contract Management (Operation)               | 1.1: The Health Board should stipulate the minimum requirements for contract management based on the level of risk associated with each contract. This should be agreed and documented                                                                                                                                                                                                                    | 1.1: Produce a guide to service managers outlining key principles, minimum requirements for both contract spec & ongoing monitoring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/03/2022                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | Complete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                    | Not categorised by IA            |
| 484 | Internal Audit                  | Procurement: Contract Management and Single Tender Waivers | 2021    | Reasonable      | High     | Matter Arising 1: Contract Management (Operation)               | 1.2: Management should risk assess existing contracts to ensure contract management arrangements are adequate.                                                                                                                                                                                                                                                                                            | 1.2: To review all relevant contract to identify the level of risk each contract with a view to reviewing, with procurement colleagues, that appropriate arrangements are in place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/03/2022                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | Complete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Close                              | Superseded by Procurement review |
| 485 | Internal Audit                  | Procurement: Contract Management and Single Tender Waivers | 2021    | Reasonable      | Medium   | Matter Arising 2: Contract database (Operation)                 | 2.1: The Health Board should periodically review the NWSSP Procurement Database to ensure the information is up to date.                                                                                                                                                                                                                                                                                  | 2.1: The Health Board will request a quarterly contract report from the NWSSP Procurement Services and review the detail at the relevant P2P meeting for accuracy. All inaccuracies will be flagged for update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/01/2022                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | Quarterly reviews of the procurement database will form part of the agenda and will be reviewed formally by the finance P2P group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    | Not categorised by IA            |
| 614 | Internal Audit                  | Maternity Cross-Border Arrangements                        | 2021    | Reasonable      | Medium   | Matter Arising 1 - Policy and legislative requirements (Design) | The legal rights of Welsh mothers requesting to give birth outside of Wales must be established or confirmed to support and inform the request and assessment process.                                                                                                                                                                                                                                    | 1.1: BCUHB Contracting Team to seek Legal Advice from NWSSP Legal & Risk Services on behalf of the Women's Service regarding the legal right of Welsh mothers requesting to give birth outside of Wales.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 30/12/2021                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | Following legal advice no further action is required and the stated audit has been completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    | Not categorised by IA            |
| 615 | Internal Audit                  | Maternity Cross-Border Arrangements                        | 2021    | Reasonable      | Medium   | Matter Arising 2 – Review and appeal process (Operation)        | Women's Division will appraise the robustness of their review and appeal process and update documentation where necessary to ensure continued relevance. To enable greater scrutiny and understanding management should consider recording the stated reasons that mothers give for wanting to give birth in England, and periodically review and reconcile register information to actual activity data. | 2.1: Women's Division will review its appeals process once legal advice has been secured in relation to the legal rights of Welsh mothers requesting to birth outside of Wales                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/01/2022                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | All actions completed. Legal advice been secured and related documents updated and re-issued. Local request register on reasons to birth outside of North Wales is monitored at Women's F&P on a quarterly basis this includes Contracting monitoring and Contracting representation is in attendance. A full year effect has been audited and presented to the Women's Service Board in January 2022.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | Not categorised by IA            |
| 616 | Internal Audit                  | Maternity Cross-Border Arrangements                        | 2021    | Reasonable      | Medium   | Matter Arising 2 – Review and appeal process (Operation)        | Women's Division will appraise the robustness of their review and appeal process and update documentation where necessary to ensure continued relevance. To enable greater scrutiny and understanding management should consider recording the stated reasons that mothers give for wanting to give birth in England, and periodically review and reconcile register information to actual activity data. | 2.2: Related documents have been updated and re-issued to support process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | N/A                          |                             | 0                   |                            |                     | Implemented - Final Client Approved | All actions completed. Legal advice been secured and related documents updated and re-issued. Local request register on reasons to birth outside of North Wales is monitored at Women's F&P on a quarterly basis this includes Contracting monitoring and Contracting representation is in attendance. A full year effect has been audited and presented to the Women's Service Board in January 2022.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | Not categorised by IA            |
| 617 | Internal Audit                  | Maternity Cross-Border Arrangements                        | 2021    | Reasonable      | Medium   | Matter Arising 2 – Review and appeal process (Operation)        | Women's Division will appraise the robustness of their review and appeal process and update documentation where necessary to ensure continued relevance. To enable greater scrutiny and understanding management should consider recording the stated reasons that mothers give for wanting to give birth in England, and periodically review and reconcile register information to actual activity data. | 2.3: Women's reasons for wanting to birth outside of Wales is currently captured on the request form. To support a thematic review of the reasons women wish to birth outside of North Wales, the local request register will include Women's reasons for requesting. Reasons for any requests will be monitored quarterly at the Women's Finance and Performance Group, which includes Contracting Representation, outputs of which will be used in future to inform Contracting and Commissioning discussions.                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/12/2021                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | All actions completed. Legal advice been secured and related documents updated and re-issued. Local request register on reasons to birth outside of North Wales is monitored at Women's F&P on a quarterly basis this includes Contracting monitoring and Contracting representation is in attendance. A full year effect has been audited and presented to the Women's Service Board in January 2022.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | Not categorised by IA            |
| 618 | Internal Audit                  | Maternity Cross-Border Arrangements                        | 2021    | Reasonable      | Medium   | Matter Arising 2 – Review and appeal process (Operation)        | Women's Division will appraise the robustness of their review and appeal process and update documentation where necessary to ensure continued relevance. To enable greater scrutiny and understanding management should consider recording the stated reasons that mothers give for wanting to give birth in England, and periodically review and reconcile register information to actual activity data. | 2.4: Periodic review of information held on the request register will be undertaken against the actual activity data on a quarterly basis at the monthly Women's Finance and Performance meetings which includes contracting and commissioning monitoring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28/02/2022                   |                             | 0                   |                            |                     | Implemented - Final Client Approved | All actions completed. Legal advice been secured and related documents updated and re-issued. Local request register on reasons to birth outside of North Wales is monitored at Women's F&P on a quarterly basis this includes Contracting monitoring and Contracting representation is in attendance. A full year effect has been audited and presented to the Women's Service Board in January 2022.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | Not categorised by IA            |
| 629 | Internal Audit                  | Risk Management                                            | ?       | Reasonable      | Low      | DATIX                                                           | All information evidencing the escalation route is included in Datix (within documents) thus providing a robust evidence to underpin its inclusion.                                                                                                                                                                                                                                                       | The recommendation is accepted. The requirement to ensure all information is adequately stored is Datix to support each risk is being covered as part of the delivery of the RM03 – Risk Management Training Programme. Regular Key Performance Indicators (as described in the RM01 – Section 18 – Performance Measurement and Monitoring of Risk Management Culture) are in place. This will be strengthened to include a sample review of the documents to support escalation within the current revision of the RM01.                                                                                                                                                                                                                                                                                                                                                                                                                   | 09/07/2021                   | 31/08/2021                  | 1                   | 15/08/2021                 |                     | Implemented - Final Client Approved | There is greater emphasis during Risk Management Trainings i.e. during both the Fundamentals of Risk Management and Operational Risk Management trainings including How to Add a new risk, for risk owners, handlers and senior managers to ensure that appropriate information underpinning the escalation of risks is adequately captured on Datix especially 'under the progress notes section'. The need to ensure that information around risk escalation is captured on Datix has also been underlined in the updated RM01 - Risk Management Strategy and Policy and the RM03 - Risk Management and Assurance Training Plan. Key performance indicators which are now regularly reported to the Risk Management Group have also been setup and incorporated into the updated RM01 to monitor and evaluate compliance. |                                    | Not categorised by IA            |
| 644 | Internal Audit                  | Roster management                                          | 2019/20 | N/A             | Medium   | Timesheets supporting payments                                  | A full internal audit review is undertaken of the system when circumstances allow for further verification facilitated by ward/departments visits.                                                                                                                                                                                                                                                        | It is acknowledged that this Audit could not effectively take place as due to the outbreak of COVID-19 there was limited capacity internally and with external agencies to provide enough data to produce a robust set of findings. In light of this, the initial review has resulted in limited assurance with a recommendation to undertake a fuller review. Management are in agreement that next steps are to re-schedule the review in a timely manner to ensure stakeholders involved will have capacity to input into the audit. In the meantime BCUHB bank team is continuing to work with divisional managers over the importance of them carefully checking shifts worked before locking down the roster to authorise for payment. In addition the all Wales Agency Nursing Services (AW4931) contract is due for renewal in February 2021. BCU has requested to NWSSP that any revisions to this contract include sample testing | 30/06/2021                   | 30/08/2021                  | 1                   | 16/09/2021                 |                     | Implemented - Final Client Approved | Audit scope agreed subject to confirmation of start date. This will be in place by 30th September at the latest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    | Not categorised by IA            |
| 648 | Internal Audit                  | Roster management                                          | 2019/20 | N/A             | High     | Weekly exception reports                                        | 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.                                                                                              | 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). Compliance with Roster Management Policy (and SOP) to be included in Monthly Workforce Performance Reports considered by senior management teams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 30/06/2022                   |                             | 0                   | 09/08/2022                 |                     | Implemented - Final Client Approved | This has now been implemented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Evidence required to close action. |                                  |

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| 649 | Internal Audit | Secondary Care Division – Ysbyty Glan Clwyd | 2021    | N/A        | High   | Matter Arising - ISS.1 - Implementation of the quality governance review recommendations (Operating effectiveness) | 1.1a: The action plan should be revisited to address the Acute Care Director's note to the Quality, Safety and Experience Committee that actions become transformational to address the findings. 1.1b: The revised action plan is subsequently updated to establish the status of revised actions and effective monitoring arrangements established and implemented, noting the actions being implemented via the 'Restart ' Programme. 1.1c: The HMT should be provided with regular updates on the actions to ensure that areas where issues are outstanding are identified and actions taken to progress completion. | 1.1a: It had been agreed that the action plan would be refreshed (as per the July 2021 QSE discussion) when the full HMT was in place. Unfortunately due to the long term absence of the Director of Nursing (5 weeks in to post) this refresh had not happened at the time of publication of the internal audit review. It is now being taken forward and an experienced Interim Director of Nursing commenced on 24th November 2021. 1.1b) A retired senior nurse had been engaged via a bank contract to programme manage this stream of work. Due to the long term absence of one of the site's Heads of Nursing, the individual was pulled to cover that role at the end of June 2021. Since the publication of the internal audit review, workforce plans have been reviewed and arrange ments will be in place to adequately resource this work from week commencing 6th December 2021. 1.1c) The Governance Review update is a standing item via the weekly (minuted) Hospital Management Team meeting from week commencing 29th November 2021. An issues log has been developed to maintain oversight of where actions are off-track. The Restart Programme is the YGC site's transformational change programme. When the refresh action plan is signed off, it will be managed via that structure (Prince Methodology) going forward.                                                                                                                                                                                                                                         | 31/01/2022 |            | 0 | 31/01/2022 |  | Implemented - Final Client Approved | See status update. Paper drafted for site PSQ meeting 3/2/22 for onward submission through Secondary Care PQS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Evidence required to close action. |                       |
| 650 | Internal Audit | Secondary Care Division – Ysbyty Glan Clwyd | 2021    | N/A        | High   | Matter Arising - ISS.2 - Ysbyty Glan Clwyd Governance arrangements (Control design)                                | 2: The Acute Care Director: 2.1a: Ensures the governance structure mirrors that of the Health Board. 2.1b: Reviews all established meetings and whether they add value/support deliver of effective services. 2.1c: Ensures the servicing of all meetings complies with expected governance standards including establishing cycles of business; minute-taking; submission of papers is subject to review. 2.1d: Liaises with the Office of the Board Secretary for ad-hoc support and guidance.                                                                                                                         | 2.1a) The YGC governance structure has been reviewed to mirror that of the current Health Board structure going forward. Due to the level of change and potential that the Secondary Care Division will look different in the future, care has been taken to ensure that the HMT are sighted on all key issues and risks (regardless of whether they also report direct from a meeting on the site in to Secondary Care) and a YGC Site Board has been added as a means of escalation and cascade. 2.1b) All core meetings will be chaired by a member o f the HMT. During Q4, all meetings will be critically reviewed to ensure that they are effective and add value. 2.1c) Terms of Reference will be reviewed to ensure that expected governance standards are met , including format and submission of papers to e nable robust decision making and monitoring of attendance / quoracy. In meetings where it is appropriate, an annual cycle of business will be introduced with monitoring to ensure this is complied with. All meetings will conclude with a discussion on meeting effectiveness. 2.1d) Advice has been sought from corporate teams to ensure that the corporate structure is mirrored. Pending review of the Health Board's Operating Framework, this may need to be revisited in future, given the current reporting arrangements through Secondary Care.                                                                                                                                                                                                     | 31/03/2022 |            | 0 | 22/03/2022 |  | Implemented - Final Client Approved | As per status update - actions complete apart from full implementation of the Governance Structure (with a YGC Site Board) as advice from corporate team has been to await the implementation of the new operating model, rather than change arrangements to change again within a short timeframe.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Evidence required to close action. |                       |
| 651 | Internal Audit | Secondary Care Division – Ysbyty Glan Clwyd | 2021    | N/A        | High   | Matter Arising - ISS.3 - Financial governance - Delivery of savings (Operating effectiveness)                      | 3: The Acute Service Director: 3.1a Ensures, whilst using the opportunity to transform services, that all Directorate Management Teams engage and identify opportunities for efficiencies that deliver recurring cash releasing savings. 3.1b Ensures the Site Performance, Finance & Information Governance Committee meeting scrutinise operational management in their delivery of financial savings with clear actions noted for Officer(s) to be held to account.                                                                                                                                                   | 3.1a: The Restart Programme is the YGC site's vehicle to transform services in a patient-centred way that maximises the opportunity for efficiency and evidence-based practice. As part of the refresh of site governance arrangements, there is a new business case review group that considers all developments, including benefits realisation. In addition, a site Savings Collaborative meeting has been introduced (first meeting on Friday 3rd December 2021) to re-energise the programme to identify cash releasing savings and include a cross section of staff (clinicians and not just management teams.) 3.1b: There has been a Savings Meeting in place twice a month since June 2021. Whilst actions were identified, this was not minuted and it is acknowledged that progress has been limited in taking forward PIDs and bringing savings schemes in to delivery. 2 Programme Managers have been engaged on an interim basis until 31st March 2022 as part of Restart. Going forward, it would be helpful if dedicated Service Improvement resource could be made available to work with operational teams to take forward and embed the approach to savings delivery. The Directorate General Manager will be the officer for each Directorate in terms of accountability, through to the Acute Care Director at site level.                                                                                                                                                                                                                                         | 31/03/2022 |            | 0 | 22/03/2022 |  | Implemented - Final Client Approved | As per status update on 22/3/22, 3.1a and 3.1b are fully implemented.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Evidence required to close action. |                       |
| 652 | Internal Audit | Upholding Professional Standards in Wales   | 2021    | Reasonable | Medium | Matter Arising - ISS.1 - UPSW reporting to Board/Committee (Operating effectiveness)                               | To strengthen compliance with UPSW requirements: <ul style="list-style-type: none"> <li>The Designated Board Members (DBM) are noted as co-authors of the UPSW report to Committee (as they formally agree the report as part of the Joint Case Review meetings).</li> <li>The RATS Committee Terms of Reference are updated to include a DBM as a formal Member of the Committee, thus providing independent assurance to Committee/Board on the UPSW process.</li> <li>The Medical Director and/or Deputy Responsible Officer are formally invited to the</li> </ul>                                                   | Designated Board members to be noted as co-authors of the UPSW report from October RaTS Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/10/2021 |            | 0 | 30/11/2021 |  | Implemented - Final Client Approved | Updated terms of reference for RATs committe. – the UPSW co-authorship element was implemented at the last R&TS meeting in October and I have made the required terms of reference amendments – which are going to the R&TS meeting this Thursday 2.12.21. Approval at 14/12/21 audit committee. Medical Director/Deputy Responsible Officer (Evan Moore) chairs case review meetings.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                    | Not categorised by IA |
| 653 | Internal Audit | Upholding Professional Standards in Wales   | 2021    | Reasonable | Medium | Matter Arising - ISS.2 - Scheme of Reservation and Delegation (Operating effectiveness)                            | The Board Secretary: <ul style="list-style-type: none"> <li>Considers updating the Health Board SoRD to specifically reference UPSW /stages of UPSW.</li> <li>Ensures the Medical Director accurately records within their operational SoRD the role of Deputy Responsible Officer and the authority delegated to the role.</li> </ul>                                                                                                                                                                                                                                                                                   | The recommendations concerning the addition of UPSW and the stages of UPSW to the Health Board SORD will be taken forward as part of a review of the SORD currently underway. This will also include ensuring that the Medical Director records the role and authority of the Deputy Responsible Officer within their operational SORD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30/11/2021 | 31/01/2022 | 1 | 04/03/2022 |  | Implemented - Final Client Approved | Completed, incorporated within section 56 of Master SORD, and also within operational SORD as provided by the Office of the Medical Director. Master SORD is due to be reviewed by Audit Committee on 15th of March, and the operational SORD will be considered in phase 2 of the process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                    | Not categorised by IA |
| 654 | Internal Audit | Statutory Compliance – Asbestos Management  | 2021    | Reasonable | High   | Matter Arising - ISS.1 - Contractors (Operating effectiveness)                                                     | Consideration should be given as to how the Health Board is able to provide assurance that all contractors are receiving the necessary asbestos information before beginning any work on Health Board premises.                                                                                                                                                                                                                                                                                                                                                                                                          | Estates and Facilities have a Contractors Safety Guidance Document (Standard Operating Procedure) which has been prepared to cover the basic requirements for health & safety that apply to Contractors working on premises owned or occupied by BCUHB with the aim of providing a safe and secure environment for staff, contractors, patients, and members of the public. Section 24 of the document requires that the asbestos register must be inspected and used in the preparation of the health and safety "Information Pack" and prior to the commencement of any contract activity. This process ensures that the Health Board is discharging it legal duty under its requirement to manage Asbestos within its portfolio of buildings. To provide assurance that all contractors are receiving Asbestos related information at the commencement of work on Health Board premises the following actions have been taken:- <ol style="list-style-type: none"> <li>Introduction of assurance audits in support of compliance with Section 24 of the 'Contractors Safety Compliance Document to determine the level of contractor compliance.</li> <li>For assurance and escalation these audits will be reported as part of the performance management agenda at the Asbestos</li> </ol>                                                                                                                                                                                                                                                                                         | 29/10/2021 | 24/01/2022 | 1 | 26/11/2021 |  | Implemented - Final Client Approved | Contractor Auditing has now been implmented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Evidence required to close action. |                       |
| 655 | Internal Audit | Statutory Compliance – Asbestos Management  | 2021    | Reasonable | Medium | Matter Arising - ISS.2 – Training (Operating effectiveness)                                                        | Management should identify staff that are required to undertake the Asbestos Awareness training and put plans in place for this to be completed to achieve a higher level of compliance in line with targets.                                                                                                                                                                                                                                                                                                                                                                                                            | Estates and Facilities have a comprehensive programme of Asbestos Training relating to roles and functions. Asbestos Awareness training is required annually as is provided through an on-line portal. At the time of audit, the compliance level was 43%, the compliance at the end of August is now 84%. Estates and Facilities have reviewed the Asbestos Awareness training compliance to ensure that all staff are trained annually in compliance with the Health Board's Asbestos Management Policy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 29/10/2021 |            | 0 | 16/11/2021 |  | Implemented - Final Client Approved | Training matrix in place and progress detailed as per attached document.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | Not categorised by IA |
| 696 | Internal Audit | Business Continuity Arrangements            | 2018/19 | N/A        | High   | Compliance with Health Board Policy                                                                                | Corporate business continuity management ensure the Policy is complied with and obtains regular assurance, for subsequent reporting, of compliance from officers accountable for its implementation.                                                                                                                                                                                                                                                                                                                                                                                                                     | A Business Continuity Group (BCG) has now been established and will meet biannually (the frequency can be reviewed at subsequent meetings). The first meeting has been scheduled for Monday 21st June 2019. A draft Terms of Reference will be circulated for comment at the Civil Contingencies Group in June and is attached herewith. Annual testing of departmental plans will be a standing agenda item at the BCG. An exercise schedule will be prepared and exercises will be facilitated and supported by the newly appointed Business Continuity Manager (this position is Business Continuity Manager June 30th 2019 Business Continuity Arrangements Internal Audit Report Betsi Cadwaladr University Health Board Appendix A - Action Plan NHS Wales Audit & Assurance Services Page 11 of 16 currently being advertised with a view to appointing in June 2019). Until this position is filled, the Head of Emergency Preparedness will support and facilitate exercises. Following each exercise, the BC departmental lead will be expected to produce an exercise report and action plan and this will be reviewed at the subsequent BCG where good practice and lessons learnt will be shared. Outstanding actions will be reviewed at each meeting until complete. Training requirements will be formally reviewed at each BCG meeting. The Head of Emergency Preparedness will be delivering formal training to the BC Leads followed by a desktop exercise (Exercise Estrella) at the initial meeting in June. Training records will be held by the Resilience Unit. | 02/09/2019 | 30/11/2019 | 1 | 20/11/2019 |  | Implemented - Final Client Approved | Audit Recommendation: Corporate business continuity management ensure the Policy is complied with and obtains regular assurance, for subsequent reporting, of compliance from officers accountable for its implementation. Management Response: A Business Continuity Group (BCG) has now been established and will meet biannually (the frequency can be reviewed at subsequent meetings). The first meeting has been scheduled for Monday 21st June 2019. A draft Terms of Reference will be circulated for comment at the Civil Contingencies Group in June and is attached herewith. Annual testing of departmental plans will be a standing agenda item at the BCG. An exercise schedule will be prepared and exercises will be facilitated and supported by the newly appointed Business Continuity Manager (this position is Business Continuity Manager June 30th 2019 Business Continuity Arrangements Internal Audit Report Betsi Cadwaladr University Health Board Appendix A - Action Plan NHS Wales Audit & Assurance Services Page 11 of 16 currently being advertised with a view to appointing in June 2019). Until this position is filled, the Head of Emergency Preparedness will support and facilitate exercises. Following each exercise, the BC departmental lead will be expected to produce an exercise report and action plan and this will be reviewed at the subsequent BCG where good practice and lessons learnt will be shared. Outstanding actions will be reviewed at each meeting until complete. Training requirements will be formally reviewed at each BCG meeting. The Head of Emergency Preparedness will be delivering formal training to the BC Leads followed by a desktop exercise (Exercise Estrella) at the initial meeting in June. Training records will be held by the Resilience Unit. | Evidence required to close action. |                       |



|     |                |                                                                                                                       |         |     |        |                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |            |    |            |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                    |                                                       |
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| 697 | Internal Audit | Revenue business cases                                                                                                | 2018/19 | N/A | High   | Record of submitted business cases                                                    | The Finance Directorate ensure all revenue business cases are subject to scrutiny in accordance with the approved guidance.                                                                                                                                                                                                                                                                                                                                                                                                                 | A log of all Business Cases that have been submitted as part of the 2019/20 Financial Plan has now been produced, and will be maintained by the Planning Accountant. This is supporting a review of all new business cases included within the 2019/20 financial plan by the Finance & Performance Committee. Before any business case is submitted to the Executives for approval, a formal sign-off of the financial implications by the finance department will need to be evidenced within the document. If a formal sign-off is not evident, then the business case will be rejected immediately.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 06/09/2019 |            | 0  | 20/09/2019 |  | Implemented - Final Client Approved | New Business Case process approved by Execs and a Business Case approval group has been established                                                                                                                                                                                                                                                                                                                                                                                                   | Close                              | IA involved in revenue BC review                      |
| 698 | Internal Audit | Revenue business cases                                                                                                | 2018/19 | N/A | High   | Revenue Business Cases Guidance and Template                                          | The Assistant Director - Strategic and Business Analysis considers publishing this guidance as a formal operational procedure/Policy to be followed across the Health Board. The Health Board considers including financial limits by which decisions are delegated.                                                                                                                                                                                                                                                                        | Following discussion with the Deputy Board Secretary, it has been agreed that the guidance (when amended in light of this audit) will be published as a NonClinical Procedure, in line with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents. As a "NonClinical other written control document BCU wide" it will go to the Executive Team or EMG for approval. The revised guidance will specifically include financial limits which are in line with the Scheme of Delegation and SFIs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 06/09/2019 |            | 0  | 20/09/2019 |  | Implemented - Final Client Approved | New Business Case guidance approved by Execs                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Close                              | IA involved in revenue BC review                      |
| 699 | Internal Audit | Revenue business cases                                                                                                | 2018/19 | N/A | Medium | Management training                                                                   | Given the importance of this area, this training should be brought forward and targeted at key posts across the Health Board structure where there is a need for the post to develop/input into business cases.                                                                                                                                                                                                                                                                                                                             | Agreed. Discussions are being held with OD to agree the best way to accelerate the training.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 06/09/2019 | 31/10/2020 | 4  | 07/12/2020 |  | Implemented - Final Client Approved | Further training has taken place via a BCU-wide Masterclass and other sessions aimed at specific teams. It has been agreed to continue to continue an internal approach to training rather than seeking external support.                                                                                                                                                                                                                                                                             |                                    |                                                       |
| 704 | Internal Audit | Infection Prevention and Control - Safe, clean care                                                                   | 2018/19 | N/A | Medium | Policies, Procedures and Guidelines                                                   | All policies, procedures and guidelines presented on the intranet that are associated with the IP and SCC Campaign should be reviewed and updated accordingly. The SCC Tracker should be updated to incorporate this requirement.                                                                                                                                                                                                                                                                                                           | This is being currently addressed with a programme of work to update all the required policies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 31/03/2020 | 31/03/2023 | 16 | 15/02/2023 |  | Implemented - Final Client Approved | The IPT have developed a robust process, overseen by IP SG and Team Central, for the review, update and approval of IP related policies, procedures and protocols in line with BCU 'OBS1 Management of Policies & Procedures and other Written Control Documents'. Currently there are no IP documents out of date, with the next document due for review by June 2023. Furthermore, the IPT are proactively developing new IP and Decontamination protocols and SOPs.                                |                                    |                                                       |
| 708 | Internal Audit | The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6, Part 7 | 2018/19 | N/A | High   | Timescale compliance                                                                  | Management must ensure compliance with relevant statutory and policy requirements. Management should consider whether controls in place are sufficiently robust to ensure future compliance.                                                                                                                                                                                                                                                                                                                                                | The Corporate Concerns Team to be restructured to provide a single lead for Complaints across BCUHB. PTR1a, the procedure for the management of Concerns to be revised and updated to make it easier for staff to follow and drive the appropriate and timely decision making regarding qualifying liability. The establishment of a weekly meeting lead by the Associate Director of Quality and Assurance to review complex and significantly overdue complaints. The weekly Corporate Concerns Hub provides weekly performance/monitoring reports for all divisions to support performance monitoring. All concerns are reviewed by the Head of Complaints on a weekly basis to drive progress and monitor progression of investigations into qualifying liability. Further training regarding the investigation of complaints to determine Breach of duty of care and qualifying liability to be provided across BCUHB. This programme has commenced and is a rolling programme but it will take time to reach all appropriate staff.                                                                                                                                                       | 30/04/2020 | 31/05/2021 | 4  | 30/04/2021 |  | Implemented - Final Client Approved | The new complaints process and new incident process are rolling out from April 2021. A letter was issued to services from the CEO and DCEO outlining the new process. A performance dashboard is in place to monitor progress. The revised PTR policy is going to the next QSE for approval.                                                                                                                                                                                                          | Close                              | Superseded - complaints review to be included 2025/26 |
| 712 | Internal Audit | Managing the Outpatients Backlog                                                                                      | 2018/19 | N/A | High   | Outpatients Backlog Data Accuracy and Completeness                                    | A risk assessment is undertaken as a matter of priority to identify all overdue outpatient appointments which may either be a USC/urgent nature. Further validation needs to be completed to identify overdue follow up appointments which need to be issued as a matter of urgency for the patients concerned. Where there are clinic capacity issues to allocate overdue appointments there needs to be a robust escalation process developed and followed with update/reporting assurance mechanism to senior Secondary Care Management. | A specific data validation exercise will need to be undertaken to ensure all records are active followed by a clinical desk based review to prioritise and action care plans. Therefore, alongside presentation of this report, an assessment of the clinical and administrative resources required to meet this objective will need to be made as it is not possible to achieve the action without either substituting this activity for others or creating additional capacity. Initially, we need to identify the resource as a priority in order to define the timescales for the programme of work. The SOP detailed below (ISS.2) will incorporate escalation arrangements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01/05/2019 | 31/12/2020 | 9  | 07/12/2020 |  | Implemented - Final Client Approved | FU backlog trajectory to reduce FU backlog in line with WG 2 year target 2019/20 and 2020/21 is in situ and is being monitored via weekly access meetings where assurance has been provided by hospital directors who present against a dashboard that reflects the trajectory to the actual.                                                                                                                                                                                                         | Evidence required to close action. |                                                       |
| 713 | Internal Audit | Managing the Outpatients Backlog                                                                                      | 2018/19 | N/A | High   | No Overarching Procedures regarding Managing the Outpatients Backlog are in place     | The Health Board develop operational guidance to ensure WHC guidance is adhered to and embedded to ensure Outpatient Follow up appointments Backlog is effectively monitored and managed and that patient care is of the highest, safest standard.                                                                                                                                                                                                                                                                                          | Draft SOP has been developed at Ysbyty Gwynedd. This will be updated to incorporate WHC Guidelines and standardised for all delivery units. (This will be through the Follow Up Clinical Safety and Improvement Group).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 01/05/2019 | 31/12/2020 | 13 | 07/12/2020 |  | Implemented - Final Client Approved | FU dashboard in place and tracking against trajectory is undertaken weekly via access meetings with HMT. As at end Nov / early Dec reductions are evident in the backlog prevention and reduction overall evident via the new FU backlog breach dashboard and mitigates from the backlog breach increasing.                                                                                                                                                                                           | Evidence required to close action. |                                                       |
| 714 | Internal Audit | Managing the Outpatients Backlog                                                                                      | 2018/19 | N/A | High   | Management Oversight and Scrutiny                                                     | Management review the reporting arrangements for regular reporting and scrutiny of the outpatients backlog.                                                                                                                                                                                                                                                                                                                                                                                                                                 | The total number of overdue follow-up outpatients are reported within the corporate performance information, as part of the Timely Care National Standards metrics (DM62). However, detailed specialty and timing measures are not reported. The Planned Care Delivery Group is being constituted during January 2018 and will be taking reports from the newly formed clinically led Follow Up Clinical Safety and Improvement Group. This group was constituted in December and is developing a suite of reports to support its work.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 01/05/2019 | 31/10/2019 | 2  | 04/10/2019 |  | Implemented - Final Client Approved | [04/10/2019 15:36] Bethan Wassell (BCUHB - Office of the Board Secretary): Backlog continues to be monitored at specialty and site level weekly Patient Tracking List (PTL) meeting. Additionally RTT performance management meeting chaired by exec lead is in place from 22nd Aug 19 to maintain oversight of waiting list position for RTT FU and endoscopy. Speciality level target for Treat in turn in place. Oversight of progress is monitored as the Quality, Safety & Experience Committee. | Evidence required to close action. |                                                       |
| 715 | Internal Audit | Managing the Outpatients Backlog                                                                                      | 2018/19 | N/A | Medium | Transformation Programmes                                                             | Governance arrangements for assurance reporting of the Transforming Outpatients Programme Board are clarified within the organisational reporting and accountability structure                                                                                                                                                                                                                                                                                                                                                              | This will be to the Planned Care Delivery Group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01/05/2019 |            | 0  | 28/11/2019 |  | Implemented - Final Client Approved | Governance processes in place                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                                                       |
| 716 | Internal Audit | Managing the Outpatients Backlog                                                                                      | 2018/19 | N/A | High   | Outpatient Follow up Waiting List - data sample Testing – YGC, YG, WXM hospital sites | Management undertake a focused data cleansing exercise to ensure Outpatients overdue follow up appointments only include patients waiting for follow up appointments along with ensuring Clinic Outcome forms are retained and scanned in to patient records to ensure a full audit trail.                                                                                                                                                                                                                                                  | For large numbers of patients, as part of the follow-up outpatient recovery actions being overseen by the Planned Care Delivery Group, it is expected that a full data validation exercise will be undertaken to ensure all records are active. A clinical desk based review, a non face-to-face appointment and/or a face to face appointment will follow. This is linked to completion of cleansing data as articulated, recommendation ISS.1. Alongside presentation of this report, an assessment of the clinical and administrative resources required to meet this objective will need to be made as it is not possible to achieve the action without either substituting this activity for others or creating additional capacity; Development of the process and standards method for implementation across the sites with monitoring, oversight and scrutiny via the Planned Care Group; To be included in the Terms of Reference for                                                                                                                                                                                                                                                  | 01/05/2019 | 31/12/2020 | 12 | 07/12/2020 |  | Implemented - Final Client Approved | validation is in place and continues as an ongoing process. SOS and PIFU pathways are in place and conversions onto these pathways are being monitored by SOS / PIFU dashboard and are also monitored and discussed with WG regularly. These actions support mitigation against an increasing backlog.                                                                                                                                                                                                | Evidence required to close action. |                                                       |
| 717 | Internal Audit | Implementing the Falls strategy                                                                                       | 2018/19 | N/A | Medium | Evidence of reporting progress since the launch of the falls policy                   | Regular reporting on falls management is consistent with the established requirements set out in the Policy and defined groups accountable for implementing and monitoring.                                                                                                                                                                                                                                                                                                                                                                 | The revised TOR for the Falls group now identifies quarterly meetings for the group. Minutes of the Inpatient group will be sent to QSG following each meeting along with a summary report on activity. Monthly falls performance reports to QSG will be provided through the three Area, three acute site and one MH&LD divisional exceptions reports to QSG. The In-patient Strategic Falls group acknowledges that attendance has deteriorated which has slowed the progression that could be made within inpatient falls prevention and management. Attempts have been made to encourage an increase in availability to attend these meetings. The Chair of the group will escalate this in writing to the Executive Director of Nursing (Executive lead) and agree a response. Furthermore the leadership of the group, the level of funded organisational subject expertise to support the group and its Terms of Reference will be reviewed by the Executive Director of Nursing.                                                                                                                                                                                                        | 31/01/2019 | 14/03/2019 | 1  | 12/04/2019 |  | Implemented - Final Client Approved | Divisional reports of issues of significance reported monthly to QSG. Chair of inpatient falls group has written to Director of Nursing on the 4th March 2019 to request support in regard to attendance from divisions and review the leadership and terms of reference of the group.                                                                                                                                                                                                                |                                    |                                                       |
| 718 | Internal Audit | Implementing the Falls strategy                                                                                       | 2018/19 | N/A | High   | Evidence of reporting progress since the launch of the falls policy                   | Policy requirement is reviewed to ensure it is both achievable and suitable. Also falls management training is included as mandatory for all relevant staff within ESR.                                                                                                                                                                                                                                                                                                                                                                     | Training of staff in the area of falls prevention awareness is mandatory for ward based staff. It is the remit of clinical divisions to ensure that the mandatory training falls prevention awareness module on ESR (000 Preventing Falls in Hospitals) is cascaded and made available to all relevant staff. It is currently available on the ESR catalogue and will also be easily found via signposting from the BCUHB Intranet Falls Prevention Homepage once it is launched. Compliance reporting was initially difficult following the change from e-learning to ESR as the portal of access to the training. The Falls group will review the access to the training and its ability to report compliance. The group will review the suitability of the module as a form of training and make a recommendation to the Executive lead as to possible other approaches, such as face to face training which have not been achievable to date due to lack of funding/ resources to support this model. To achieve this, Executive support will be required to establish a framework similar to that of other major harms prevention teams such as Infection Prevention and Tissue Viability. | 31/03/2019 | 31/10/2019 | 2  | 30/09/2019 |  | Implemented - Final Client Approved | Falls training is mandatory for all nursing and HCSW staff across the Health Board. The Falls Policy was reviewed in 2018 and is being further reviewed as part of the all Wales documentation                                                                                                                                                                                                                                                                                                        | Close                              | Superseded by falls review 2023                       |
| 719 | Internal Audit | Implementing the Falls strategy                                                                                       | 2018/19 | N/A | High   | Review the DATIX reporting system and the reporting of patient falls                  | Compliance with Health Board Falls Management Policy – Section 8.3.2 – “A post falls root cause analysis template action record must be completed for all falls which cause harm”.                                                                                                                                                                                                                                                                                                                                                          | As part of the review of the NU06 policy and attached documents, it will be discussed whether the falls prevention specific RCA attached to this policy is surplus to requirements within the RIDDOR framework as other RCA tools have been seen to be used, thus fulfilling the reporting framework. Compliance with RCA completion will form part of the reporting schedule identified in recommendation ISS.1 above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/03/2019 | 26/11/2019 | 2  | 30/09/2019 |  | Implemented - Final Client Approved | All Falls with harm are subject to a Root Cause Analysis (RCA) and are then discussed as part of a desk top review                                                                                                                                                                                                                                                                                                                                                                                    | Close                              | Superseded by falls review 2023                       |
| 721 | Internal Audit | Implementing the Falls strategy                                                                                       | 2018/19 | N/A | High   | Evidence that staff are completing the patient falls pathway                          | Improved awareness to staff with regards to the importance of the completion of the documentation as well as the consequences.                                                                                                                                                                                                                                                                                                                                                                                                              | Clinical divisions must ensure completion of the appropriate documentation within the Falls Prevention Pathway and provide assurance through regular auditing of documentation in line with wider appropriate record keeping standards. Failure to maintain adequate falls assessment and management records should be captured as part of any serious fall SIR reports and reported as exception under the divisional reporting schedule to QSG as per recommendation ISS.1 above. The strategic falls group will seek assurance from clinical divisions of lessons learnt in relation to poor record keeping following audit reports and for SIR reports.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31/01/2019 | 31/12/2019 | 2  | 30/09/2019 |  | Implemented - Final Client Approved | Falls are monitored via the Ward quality dashboard and included as part of the ward accreditation process which incorporates documentation audits. Monthly ward accreditation metrics monitor compliance and quality of completion. Wards are assessed as Bronze, Silver, Gold, White or Red for each of these areas and support mechanisms put in place.                                                                                                                                             | Close                              | Superseded by falls review 2023                       |

|     |                |                                                                                                                                           |         |     |        |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |            |   |            |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                                |
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| 725 | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | Medium | Patient feedback - Community Health Council Foodwatch/Carewatch       | All Foodwatch/Carewatch reports are subject to tracking and reporting to INCHS/FINCH (subject to any changes in governance structure) in order that issues relating to catering, nutrition and hydration are actively monitored and issues addressed.                                                                                                                                                                                                                                          | The arrangements for this are already provisionally in place subject to new agreed Foodwatch questions. The chair of INCHS will ensure a process is set up via the CHC lead on INCHS and that these are a standing agenda item at each INCHS meeting. Reporting will commence from June 2019                                                                                                                                                                                                                                                                                       | 30/06/2019 |            | 0 | 17/07/2019 |  | Implemented - Final Client Approved | Reviewed in INCHS in June 2019 and on going scrutiny will be via FINCH from September 2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                    |                                |
| 726 | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | Medium | Patient feedback - Health Board systems                               | Using existing tools and reporting methodology, management regularly evidence review of output reports to identify where returns are not improving and put in place a process where these are subject to scrutiny – We would anticipate this being a key role of INCHS to monitor and hold services to account.                                                                                                                                                                                | Service user reports will be reviewed at each INCHS and link in with ward accreditation reviews. New reporting structures will be established and in place by June 2019.                                                                                                                                                                                                                                                                                                                                                                                                           | 30/06/2019 |            | 0 | 17/07/2019 |  | Implemented - Final Client Approved | Chair of INCHS will discuss with chair of FINCH for the raw data reports to be reviewed and actions completed as required. Start date will be from September 2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |                                |
| 727 | Internal Audit | Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? | 2018/19 | N/A | High   | Ward quality and safety self-assessment and recorded patient feedback | Whilst noting the planned introduction of Ward accreditation and advised this will replace the self-assessment against the standard, management ensure there are adequate controls in situ to monitor progress between the initial accreditation and follow-up visit.                                                                                                                                                                                                                          | A process will be set up to between ward accreditation and INCHS whereby reports can be reviewed at INCHS and reviewed appropriately, with concerns escalated and managed appropriately. This will be discussed in INCHS on 7th December 2018 and a reporting structure established from there.                                                                                                                                                                                                                                                                                    | 31/03/2019 |            | 0 | 17/07/2019 |  | Implemented - Final Client Approved | Reports will be reviewed quarterly in INCHS starting in September 2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Evidence required to close action. |                                |
| 730 | Internal Audit | Patient Monies                                                                                                                            | 2018/19 | N/A | High   | Disclaimer notices and patient property Disclaimer forms              | Wards and Hospitals should display Disclaimer Notices in line with the requirements of procedure F01 and ensure in-patients sign the official disclaimer form to indemnify the Health Board against loss and damage to articles retained by the patient whilst on the ward.                                                                                                                                                                                                                    | Ensure appropriate notices are displayed in all Patient facing areas, appropriate forms are available, issued and recorded within the patient records signed and dated accordingly.                                                                                                                                                                                                                                                                                                                                                                                                | 31/10/2019 |            | 0 | 17/10/2019 |  | Implemented - Final Client Approved | notices are displayed in all patient facing areas, appropriate forms are available, staff are aware that these forms are to be issued and recorded within the patient records signed and dated accordingly.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Evidence required to close action. |                                |
| 731 | Internal Audit | Patient Monies                                                                                                                            | 2018/19 | N/A | High   | Completion of documentation and Procedural compliance                 | The Patients property procedure should be reviewed, updated and circulated to all hospitals and wards to ensure they are receipt of up to date procedural requirements. In addition, Finance may wish to consider providing training sessions to Hospitals and Wards to ensure staff are aware of procedural responsibility and the completion of documentation.                                                                                                                               | A Task and Finish Group including Nursing and Finance staff will be established in order to review and update the existing patients property procedure F01. Following distribution of the updated procedure to all hospitals and wards notices will be posted on the intranet weekly bulletins and “Things You Need to Know” with training sessions being provided as required.                                                                                                                                                                                                    | 30/11/2019 | 31/01/2020 | 2 | 13/01/2020 |  | Implemented - Final Client Approved | The updated procedure was approved by the Execs Team on 8th January and has now been updated on the Finance Policies and Key Documents page of the Health Board intranet. The new procedure will be implemented with immediate effect with support from colleagues in nursing management.                                                                                                                                                                                                                                                                                                                                                                                     | Evidence required to close action. |                                |
| 732 | Internal Audit | Patient Monies                                                                                                                            | 2018/19 | N/A | Medium | Physical security                                                     | Hospital management must ensure: Wards have a safe facility in place to ensure the temporary safe custody of patient’s property and monies. Patients must be asked to sign a disclaimer form to indemnify the Health Board against loss or damage to articles retained by the patient whilst in hospital. A mechanism should be introduced to ensure bedside cabinet keys are signed for and returned upon discharge.                                                                          | Scope of all Patient areas to ensure there is appropriate safe storage facilities available for securing belongings. An initial audit of compliance with the updated patient monies procedure will be co-ordinated by the General Office Manager.                                                                                                                                                                                                                                                                                                                                  | 31/01/2020 | 30/11/2020 | 6 | 23/11/2020 |  | Implemented - Final Client Approved | All work around ward security and placing safes into the wards has now been completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                |
| 733 | Internal Audit | Patient Monies                                                                                                                            | 2018/19 | N/A | Medium | Patients property books                                               | Finance must ensure that all wards and hospitals are in receipt of official up to date documentation and that it is being completed in line with procedure F01                                                                                                                                                                                                                                                                                                                                 | Additional supplies of official property books have recently been ordered and these will be issued via General Offices and Hospital Administration teams. Guidance on completion of property books will be provided by the General Office Manager who will also monitor on-going compliance as part of routine hospital visits.                                                                                                                                                                                                                                                    | 01/10/2019 |            | 0 | 16/09/2019 |  | Implemented - Final Client Approved | New patient property books have been issued to General Offices for onward distribution to wards and departments.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                    |                                |
| 734 | Internal Audit | Patient Monies                                                                                                                            | 2018/19 | N/A | High   | Patients Property Procedure F01                                       | Departmental responsibility for the review and update of F01 should be discussed and agreed between Nursing and Finance. An up to date procedure should be circulated around the Health Board endorsing an official consistent approach to the administration of patient’s property and monies.                                                                                                                                                                                                | A Task and Finish Group including Nursing and Finance staff will be established in order to review and update the existing patients property procedure F01. Following distribution of the updated procedure to all hospitals and wards notices will be posted on the intranet weekly bulletins and “Things You Need to Know” with training sessions being provided as required.                                                                                                                                                                                                    | 30/11/2019 | 31/01/2020 | 2 | 13/01/2020 |  | Implemented - Final Client Approved | The updated procedure was approved by the Exec Team on 8th January and has now been uploaded onto the Finance Policies and Key Documents page of the Health Board intranet. The updated procedure will be implemented with immediate effect with support from colleagues in nursing management                                                                                                                                                                                                                                                                                                                                                                                | Evidence required to close action. |                                |
| 743 | Internal Audit | Primary Care GP Leases: Assigning leases to the Health Board                                                                              | 2018/19 | N/A | High   | Standard Operating Procedure - Agreeing Schedule of Dilapidation      | Area management, with input from Estates and Finance, develop a procedure to document the process to be followed on receipt of contract termination through to the Health Board assuming responsibility for the lease.                                                                                                                                                                                                                                                                         | A detailed ‘Checklist’ is designed to be used initially during any transition to managed practice status, but also as an ongoing resource for the development of a managed practice. This provides actions to follow for Communications, IT, Workforce, Finance & Estates (F&E), Operational Delivery. The F&E list does include requirement to confirm with outgoing partners any costs associated with dilapidation that have to be paid to the landlord. A SOP for agreeing the schedule of dilapidation will be developed and embedded into this checklist for further detail. | 31/03/2019 | 28/06/2019 | 1 | 01/07/2019 |  | Implemented - Final Client Approved | with effect from 01/07/2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Evidence required to close action. |                                |
| 755 | Internal Audit | Welsh Risk Pool - Claims Management Standard                                                                                              | 2019/20 | N/A | Medium | Policy and Procedures                                                 | Service managers must ensure that all relevant policies and operating procedures are up to date, relevant, and have been subject to appropriate scrutiny and approval.                                                                                                                                                                                                                                                                                                                         | The policy was revised in 2019 as originally planned and approved by the Quality and Safety Group; however, due to an administrative oversight it was not submitted for uploading to the intranet. This has been corrected immediately when identified. A review is underway led by the new Assistant Director of Patient Safety and Experience to meet the changing needs of the service and a new document will be developed at the conclusion of this work.                                                                                                                     | 01/10/2020 | 11/12/2020 | 2 | 15/12/2020 |  | Implemented - Final Client Approved | The procedure was approved at the PSQ Groyp meeting on 11/12/20. Evidence is available in iBABS from the meeting records.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                    |                                |
| 758 | Internal Audit | Welsh Language (Wales) Measure 2011                                                                                                       | 2019/20 | N/A | High   | Post requirements                                                     | Management should review current practice and put in place controls to ensure that essential post requirements are either met or that training is undertaken allow successful applicants to meet the requirements.                                                                                                                                                                                                                                                                             | Welsh Language Requirements is essential question on the new Establishment Control Form, all vacancies that require approval, must complete this form. If the manager selects the incorrect Language Level, the Establishment Control Team make a note on the form. When the post then goes out to advert, a further check is made by both the EC Team and the Advert Team.                                                                                                                                                                                                        | 31/12/2019 |            | 0 | 31/12/2019 |  | Implemented - Final Client Approved | Welsh Language Requirements is essential question on the new Establishment Control Form, all vacancies that require approval, must complete this form. The form will automatically populate if specific fields are chosen, the EC Team however will review this to ensure it is correctly marked. When vacancies are advertised, they are advertised with 3 levels, a)welsh skills are essential b) welsh skills to be learnt upon appointment c) welsh skills are desirable. These are reviewed and approved by both the EC and double checked by NWSSP. Reports are currently being developed by the Trac Team to enable Workforce to monitor the process more efficiently. | Close                              | Superseded by follow up review |
| 759 | Internal Audit | Welsh Language (Wales) Measure 2011                                                                                                       | 2019/20 | N/A | High   | Exception justification                                               | Management should review current practice and put in place controls to ensure that the requirements of the Bilingual Skills Strategy are met. Given the current development of new vacancy justification forms, we urge managers to consider the possibility of building controls into the process e.g. removing the ability to change Welsh essential posts to Welsh desirable; building in and formalising the authorisation process for posts that cannot be advertised as Welsh essential. | In line with the changes above, there will be further development of the Portal to include when posts are re-advertised. All future re-advertisements will be signed off and agreed by the Workforce Information Systems Manager until portal has a process in place. This will be recorded centrally for monitoring purposes                                                                                                                                                                                                                                                      | 30/04/2020 | 31/05/2021 | 6 | 02/06/2021 |  | Implemented - Final Client Approved | Following review the current process works well, the decision has been made not to update the portal at this current time. We will however be looking for an on line system (either 365/workforce portal (when available). Assurance has been provided that no posts are advertised without being reviewed firstly. Centralised system in place.                                                                                                                                                                                                                                                                                                                              | Close                              | Superseded by follow up review |
| 760 | Internal Audit | Welsh Language (Wales) Measure 2011                                                                                                       | 2019/20 | N/A | Medium | Policy and reporting                                                  | Management should: Consider whether current practice meets the requirements of the Bilingual Skills Strategy. Review the Bilingual Skills Strategy to ensure the requirements are consistent with current working practice and systems in place. Consider whether current reporting provides sufficient assurance to the Board.                                                                                                                                                                | The Bilingual Skills Strategy will be reviewed in line with the Welsh Language Standards. There are however developments in Trac which will be live by 1 st December to ensure that the HB can report easily                                                                                                                                                                                                                                                                                                                                                                       | 31/01/2020 | 15/04/2021 | 4 | 29/04/2021 |  | Implemented - Final Client Approved | Policy has been approved at the Strategy, Partnership and Population Health Committee on 15 April 2021.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                    |                                |



|     |                |                                                |         |     |        |                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |            |            |   |            |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                                             |
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| 763 | Internal Audit | Partnership governance - Section 33 Agreements | 2019/20 | N/A | High   | Section 33 Agreements and compliance with Statutory Instrument | The Executive Director of Finance (delegated operational responsibility) ensures the Health Board undertakes a review of all Section 33 Agreements to ensure they remain fit for purpose, deliver the expected benefits to service users/partners and comply with the requirements of the Statutory Instrument – Agreements should then be signed as a matter of urgency. We believe a central repository, akin to health related contracts maintained by Finance Contracting section, should be applied                                                        | Finance Contracts Team will add Section 33 Agreements to the list of Contracts for the 2020/21 Financial Year onwards. West Area - A draft section 33 has been produced for the Community Equipment Store and will be progressed and signed for the financial year 2020/2021. West Area- Children's Disability Partnership. A new agreement to reflect the Gwynedd/Anglesey/BCUHB partnership will be produced with partners. Central Area – Denbighshire CeSI and Health & Social Care Support Workers Section 33 Agreements to be reviewed and signed as a matter of urgency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 01/04/2020 |            | 0 | 09/06/2020 |  | Implemented - Final Client Approved | Section 33 Patient facing Healthcare Agreements have been added to the Contracts Register. A complete list of all Section 33 Agreements is required for Annual Accounts purposes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Evidence required to close action. |                                             |
| 764 | Internal Audit | Partnership governance - Section 33 Agreements | 2019/20 | N/A | High   | Health Board as Host Partner                                   | The Executive Director of Finance ensures compliance with the requirements of the Statutory Instrument where the Health Board is Host Partner and accountable for the audit of the pooled fund accounts.                                                                                                                                                                                                                                                                                                                                                        | The Finance Department will prepare a memorandum account for the pooled budget which will be provided to all partners to the arrangement for inclusion in their respective annual accounts. The memorandum account, along with background information on the pooled budget arrangement, will be included within the Health Board's 2019-20 annual accounts submission and will be audited by Wales Audit Office in accordance with the requirements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/04/2020 |            | 0 | 05/06/2020 |  | Implemented - Final Client Approved | I can confirm that all Section 33 / Pooled budget statements were included in our 2019-10 annual accounts are currently being subject to audit. This reporting now includes the Bryn y Neuadd equipment store pooled budget where the Health Board is the host body                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Evidence required to close action. |                                             |
| 765 | Internal Audit | Partnership governance - Section 33 Agreements | 2019/20 | N/A | Medium | Reporting arrangements                                         | Area Directors, Executive Director of Finance and Board Secretary review the reporting of Section 33 Agreements through the Organisational and Committee Structure to ensure the Health Board is sighted on all partnership matters.                                                                                                                                                                                                                                                                                                                            | Reporting of Partnership funding and arrangements will be made through the Strategic Partnership & Population Health Committee (SPPH), with the first report being presented to the February 2020 Meeting. West Area - Minutes of the Community Equipment Partnership and the Children's Disability Partnership will be included in the West Area Finance and Performance Committee agenda. Central Area reporting of Partnership arrangements is managed through the Area Integrated Services Board (AISB) East Area - Oversight will be via the area Finance and Performance meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30/04/2020 |            | 0 | 08/06/2020 |  | Implemented - Final Client Approved | completed - see notes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                                             |
| 766 | Internal Audit | Delivery of savings against identified schemes | 2019/20 | N/A | Medium | Documentation Management and Approval                          | Management must ensure that the principles and requirements of the PMO Guidance document are adhered to in order to ensure that the Health Board has a consistent approach to project management. The PMO clarify the position regarding the requirements of Stage 3 approval. If direct Chief Executive Officer and Executive Director of Finance approval is not required, provision should be made to confirm that both Executives have had sight of the relevant PIDs.                                                                                      | As a consequence of the changes in the PMO in 2019/20, different PIDs used at various times throughout the year. We will ensure the guidance for 2020/21 is clear and the need for Stage 3 approval is clarified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13/11/2020 |            | 0 | 25/11/2020 |  | Implemented - Final Client Approved | Will be addressed as part of review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                             |
| 767 | Internal Audit | Delivery of savings against identified schemes | 2019/20 | N/A | High   | Saving Scheme Performance                                      | Management must ensure that the controls in place during each phase of the project life cycle are sufficiently robust so as to ensure that any planned savings are accurate and deliverable within the stated timeframes                                                                                                                                                                                                                                                                                                                                        | Agreed -Further work will be undertaken to develop robust savings plans before the PID is developed and agreed. Working in conjunction with Hospital Management, we will ensure forecasts are as accurate as possible.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 13/11/2020 |            | 0 | 25/11/2020 |  | Implemented - Final Client Approved | Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Close                              | Superseded by Delivery of HB Savings review |
| 768 | Internal Audit | Delivery of savings against identified schemes | 2019/20 | N/A | High   | Finance Reconciliations                                        | Whilst we acknowledge the impact of mid-year management changes, we urge the current Finance management team to ensure that all relevant savings reconciliation documentation are completed and retained. To ensure transparency all Finance teams should maintain a robust audit trail of key information and reports informing the reported savings position. To ensure that the Health Board reported savings position is accurate and true, provision should be made to address instances where savings are reduced or where savings are under/over-stated. | The Finance Team will ensure that all relevant savings reconciliation documentation are completed and retained. Any savings not in the ledger will be clearly documented and reconciled.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 13/11/2020 |            | 0 | 25/11/2020 |  | Implemented - Final Client Approved | Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Close                              | Superseded by Delivery of HB Savings review |
| 771 | Internal Audit | Salary Overpayments                            | 2019/20 | N/A | High   | Overpayments procedure                                         | The Executive Director of Finance considers writing-off the 13 invoices where interest has been levied as there is not governing policy or agreed procedure which allows the Health Board to raise such interest charges. The Overpayments procedure should be subject to consultation and approval at appropriate level, including unions and staff side group. The correct approval body within the Health Board should review and approve the revised Overpayments procedure.                                                                                | The Finance Department recognises that the latest approved version of financial procedure F14 Salary Overpayments / Underpayments Procedure does not include any provision for charging of interest on salary overpayments being repaid over a longer term. The Accounts Receivable team will contact each individual affected and will arrange for these thirteen invoices to be cancelled so that only the original overpaid amounts remain outstanding. The updated overpayments procedure will now be subject to a consultation process before being submitted for approval in accordance with policy OBS1 – Management of Policies & Procedures & Other Written Control Documents. Whilst this consultation process will focus on the need for the Health Board to recover all salary overpayments in full it will also consider the underlying reasons for overpayments occurring and the impact on the individuals affected.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/12/2020 | 28/02/2021 | 2 | 26/02/2021 |  | Implemented - Final Client Approved | The updated procedure was approved at the Executive Management Team meeting on 26th February 2021 and will now replace the previous version on the Health Board's intranet site.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Evidence required to close action. |                                             |
| 772 | Internal Audit | Salary Overpayments                            | 2019/20 | N/A | High   | Outstanding Debts                                              | The Health Board should continue to pursue recovery of debts in accordance with updated policy and a more consistent and systematic approach be followed to collect and clear long outstanding debts.                                                                                                                                                                                                                                                                                                                                                           | The Finance Department recognises the risk associated with outstanding invoices for salary overpayments particularly where these are being repaid over an extended period. During the last twelve months, the Accounts Receivable team has contacted all salary overpayment debtors with an instalment plan and has discussed potential ways to reduce the repayment term. Whilst this has in some cases successfully resulted in increased instalments, or debtors repaying the outstanding amount in full, many have referred to the terms of their original agreement. The Accounts Receivable team will continue to monitor longer-term salary overpayments and will contact this group of debtors again before the end of September 2020. The team also monitors compliance with agreed instalment plans each month and contacts debtors where payments have not been received within expected timescales. The updated financial procedure F14 Salary Overpayments / Underpayments Procedure is currently subject to a consultation process after which it will be submitted for approval in accordance with policy OBS1 – Management of Policies & Procedures & Other Written Control Documents. Until the procedure is approved, Accounts Receivable will continue to manage salary overpayments in line with the most recently approved version of the procedure, dated March 2018. This version of the procedure is published on the Health Board's intranet site and is available by email on request. Whilst this version does not include provision for the charging of interest on invoices being paid by instalments over extended periods, the Accounts Receivable team seeks repayment over the same timeframe that the overpayment occurred and preferably no longer than six months. Alongside the option of repayment by instalment, the Health Board offers a number of other payment methods including salary deductions and payment by debit or credit card. The Accounts Receivable Manager now prepares a monthly report of salary overpayments where there may have been a breach of Health Board procedures and shares this report with colleagues within the Finance Department and Workforce & Organisational Development. | 13/11/2020 |            | 0 | 31/10/2020 |  | Implemented - Final Client Approved | The Accounts Receivable team completed a full review of all outstanding invoices relating to salary overpayments during September and contacted relevant debtors to discuss their repayment plans. Outstanding invoices are reviewed by the Financial Accountant - Reporting and Control each month to ensure that repayment plans are appropriate and that any necessary action to recover debts is taken promptly. Wherever possible the Accounts Receivable team seek to limit repayment plans to a maximum of six months and escalate any breach of an agreed repayment plan immediately. Financial procedure F14 Salary overpayments and underpayments has been updated and is currently subject to a consultation exercise prior to formal approval and implementation. | Evidence required to close action. |                                             |
| 775 | Internal Audit | Decontamination                                | 2019/20 | N/A | High   | Self-audit tool findings and evidence of submission            | Chairs of the Local Health Economy Local Infection Prevention Groups ensure self-audit tools are routinely presented and discussed in accordance with current timescales.                                                                                                                                                                                                                                                                                                                                                                                       | A Decontamination/Infection Nurse role has been agreed and funding. This has been out for expressions of interest and will interview w/c 13th July 2020. This post will support the Decontamination advisor pan BCU supporting the governance structure regarding practice, self-audit and reporting. Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 13/11/2020 |            | 0 | 07/12/2020 |  | Implemented - Final Client Approved | Decontamination audits are now a standard agenda item at the Local Infection Prevention Groups. Any issues of significance or gaps are required to be reported for the LIPG to the Strategic IPSG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Evidence required to close action. |                                             |
| 776 | Internal Audit | Decontamination                                | 2019/20 | N/A | Medium | Self-audit tool findings and evidence of submission            | Decontamination Advisor to include a question on COSHH assessment which identifies that the chemicals have been assessed correctly for the area and reviewed.                                                                                                                                                                                                                                                                                                                                                                                                   | Question on COSHH assessments to be added to audit tool.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 13/11/2020 |            | 0 | 26/11/2020 |  | Implemented - Final Client Approved | Question On COSH assessment now included in the audit tools. Revised document circulated to all decontamination group members. Please find all 5 audit tools attached, record of meeting where discussed and email correspondence sent to leads informing of changes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                                             |
| 777 | Internal Audit | Decontamination                                | 2019/20 | N/A | High   | Governance – Local Infection Prevention Groups                 | The Local Health Economy Local Infection Prevention Groups ensure all issues of significance recorded in Minutes are escalated.                                                                                                                                                                                                                                                                                                                                                                                                                                 | Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13/11/2020 |            | 0 | 07/12/2020 |  | Implemented - Final Client Approved | Governance and reporting arrangements have been updated for infection prevention from the Ward to Board. Decontamination audits are now a standard agenda item at the Local Infection Prevention Groups. Any issues of significance or gaps are required to be reported for the LIPG to the Strategic IPSG                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Evidence required to close action. |                                             |

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| 778 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) | 2019/20 | N/A | Medium | Lack of local procedure                    | Supervisory Body. An up to date procedure should be produced and consideration given to short guidance for staff on wards that identifies action they should be taking and clarifies timescales. Staff should then be made aware of new policies / guidance and all published on intranet.                                                                                             | The DoLS Manager will lead and be supported to produce a Standard Operating Procedure (SOP) which will provide additional guidance for staff across the Health Board. Actions, timescales and a rationale for responding to an actual or potential deprivation of a patient. Ratification will take place through the Safeguarding Governance and Reporting Framework; which is the, Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group (QSG).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/05/2020 |            | 0  | 18/05/2020 |  | Implemented - Final Client Approved | A SoP has been developed (PDF and Word documents) which fully updates the previous document at has been in place since 2014 and was outdated. This needs sign off through the Board usual process but it is completed and will be put onto the Corporate safeguarding webpage and also be highlighted in the next Newsletter Corporate safeguarding Bulletin.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       |                           |
| 779 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) | 2019/20 | N/A | High   | Shortage of Best Interest Assessors (BIAs) | Supervisory Body. The funded establishment of BIA is reviewed as a matter of urgency to address the current delay in undertaking DoLS assessments and the pending introduction of the Liberty Protection Safeguards (LPS). The risk of financial penalties arising due to the delays in undertaking DoLS assessments be included, with action planned, in the corporate risk register. | In the immediate, the DoLS Manager will complete an Establishment Control Form to process the vacant post to be advertised. The post is currently on hold due to the Health Board's budget pressures, however as a result of the recent papers to QSG additional consideration must be given, as all current and new post holders will require new LPS training which has yet to be developed by the universities. The pending development of LPS being implemented in England and Wales has delayed some progress relating to the development of procedures and additional guidance due to the uncertainty and the delay of the publication of guidance. However after receiving training and information in February the DoLS Manager with support has produced a further report to the Quality Safety Group (QSG) to highlight the current demands and organisational risks with current DoLS service provision and the potential impact of LPS cross the Health Board and impact of LPS for the whole workforce and organisation. A further business case highlighting the financial requirements to support the service delivery will be developed as a result of the report and presented to the Finance and Performance Group. | 31/05/2020 | 18/06/2020 | 2  | 10/06/2020 |  | Implemented - Final Client Approved | The attached Establishment Control document fully signed off on 09/06/2020 and so has released the vacant post that had been on hold for budget savings. I have started the TRAC recruitment process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Close | Superseded by 2024 review |
| 780 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) | 2019/20 | N/A | High   | Completion of DoLS paperwork               | Managing Authority. All wards are reminded of the need to complete DoLS paperwork in an accurate and comprehensive manner in keeping with the stipulated requirements.                                                                                                                                                                                                                 | A Safeguarding Bulletin specifically assigned to DoLS will be produced and disseminated. The Safeguarding Ambassadors will also ensure the bulletin is disseminated within their areas and teams. The Managing Authority will develop an audit and assurance process to ensure all DoLS applications are completed accurately and correctly. The development of a SOP for DoLS should further strengthen the process and to support staff and enhance their awareness of their responsibilities and the actions to be taken to safeguard patients when a deprivation is occurring. (Finding 1) The SOP will be agreed through the existing Safeguarding Governance Framework. The dissemination will include all relevant communication processes used by the Corporate Safeguarding Team. This action directly links to Finding 1 management response above.                                                                                                                                                                                                                                                                                                                                                                         | 01/05/2020 |            | 0  | 15/04/2020 |  | Implemented - Final Client Approved | Recommendation 3: completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Close | Superseded by 2024 review |
| 781 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) | 2019/20 | N/A | Medium | Lack of engagement from DoLS signatories   | Managing Authority. Management should ensure that all nominated signatories attend training and are reminded of their obligations in respect of the DoLS process.                                                                                                                                                                                                                      | The Managing Authority will ensure Authorisers (Signatories) are reminded of their role and responsibilities through the PADR and supervision processes available to them. The DoLS Manager will include guidance reinforcing their role and responsibilities as authorisers within the Safeguarding Bulletin which is to focus specifically upon DoLS, (as above). A SOP document will be devised setting out the responsibilities for those who have been approved to authorise a DoLS. This will be signed off through Corporate Safeguarding Governance and Reporting arrangements (linked to Finding 1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/05/2020 |            | 0  | 18/05/2020 |  | Implemented - Final Client Approved | All Wards will have access to the newly created SoP which sets out the response and expectations of a Managing Authority to process a DoLS if a deprivation of liberty exists. The SOP also has two easy to follow flow chart guides as an appendices. The advancement of a SoP also enables the Supervisory Body signatories to be aware of their responsibilities. Training has been provided by the Supervisory Body through commissioning a training event on 16 January 2020 led by an experienced and skilled Barrister who identified key aspects of the role of signatories. The availability of those who are able to authorise has diminished due to COVID-19 pandemic but nevertheless extending singatories to cover their own area, in so far as there is no conflict of interest, has meant a rapid response to requests so sign off can be done within a few days. The DoLS data can scrutinise that quick response for any given case. The provision of a MCA/DoLS CoVID-19 guidance also supports the Supervisory Body response to granting a DoLS and reduce delays or difficulties engaging with patients based on national guidance. Both these documents are on the Corporate Safeguarding Webpage and will be referred within the Newsletter Safeguarding Bulletin to all BCU staff. |       |                           |
| 782 | Internal Audit | Deprivation of Liberty Safeguards (DoLS) | 2019/20 | N/A | High   | Reporting of Breaches through Datix        | Managing Authority. Wards/Departments should undertake a check of DoLS cases and monitoring records within their areas to establish whether breaches are being reported promptly. Managing Authority. Staff should be reminded that all breaches are to be reported via Datix (with appropriate CCS code.)                                                                             | The Managing Authority will undertake a random sample of Datix incidents within their responsibility to determine if breaches have been reported. The Managing Authority are to develop and to include an audit of DoLS paperwork and DoLS activities within the current Audit of records and develop a process to cross reference Datix incidents to determine whether breaches have been reported promptly. The management response of developing a SOP identified in Finding 1 and 3 authority are fully aware of their responsibilities and the consequences of breaches of Article 5 (a deprivation of liberty, Human Rights Act '98) and expectations to have in place Datix reporting and notification to the DoLS Team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 01/05/2020 |            | 0  | 21/04/2020 |  | Implemented - Final Client Approved | An electronic email record response is sent on receipt of every DoLS application. The attached breaches statement sets out that the MA needs to complete a DATIX if we receive any record which does not include either a Care Plan or a Mental Capacity DoLS Assessment. The DoLS team response if that is not forthcoming is to send an electronic email stating they are in breach of the DoLS process and we will record in our data base any record we have had to state this and they should complete a DATIX. The first DoLS application we received which has the attached statement in an email resulted in a Care Plan and Mental Capacity DoLS assessment being completed so shows that it works. The current crisis though with COVID will however have an influence on this happening consistently. As noted we will record in our data base any documents as noted which are not sent after a reminder email.. This action was taken on 15/4/20 and the first email response was sent on 16/04/20 and the first response back to that email on 17/04/20 had a Care Plan and capacity assessment attached. A care Plan                                                                                                                                                                        | Close | Superseded by 2024 review |
| 784 | Internal Audit | Cyber Security                           | 2019/20 | N/A | Medium | Regular Assurance Reporting                | The Chief Information Officer ensures the Cyber Security Policy is reviewed, formally approved and published Health Board wide.                                                                                                                                                                                                                                                        | Cyber Security Policy will be reviewed in line with ISO27001 and Cyber Essentials to ensure compliance with both. Once in post a further professional review will be undertaken by the Cyber Security and Compliance Manager and then become a regular process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 30/11/2020 | 01/05/2023 | 9  | 10/05/2023 |  | Implemented - Final Client Approved | A Cyber Security Policy has been drafted which is aligned to the principles of the ISO27001 framework This has been reviewed and approved by the Head of ICT Digital Services and the Chief Technology Officer. The Policy will now be submitted to the Corporate Policy Approval process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |                           |
| 785 | Internal Audit | Cyber Security                           | 2019/20 | N/A | Medium | Monitoring Ongoing Work                    | The Chief Information Officer ensures the implementation of all outstanding agreed actions, prioritising those that expose the Health Board to greatest risk                                                                                                                                                                                                                           | The Stratia report will be reviewed every 3 months to ensure progress continues to be made. Some of the recommendations require progress against the Cyber Essentials and ISO27001 standards as there is overlap in requirements for compliance and as such will require professional services input in the absence of a Cyber Security Team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 13/11/2020 | 30/11/2021 | 5  | 24/11/2021 |  | Implemented - Final Client Approved | As formal monitoring is now in place it is recommended that this action has been implemented and can be closed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |       |                           |
| 786 | Internal Audit | Cyber Security                           | 2019/20 | N/A | High   | Regular assurance reporting                | The Chief Information Officer provides regular assurance reports to the DIG concerning cyber security and agrees with the Committee the information it requires from management.                                                                                                                                                                                                       | The CIO will provide a standardised regular report based upon the information required by DIG. It is also vitally important that Cyber Security is added to the Corporate Risk register in line with most public sector organisations, to ensure visibility to the inevitable risks associated with Cyber Security are raised at the highest level and understood so that the organisation is sufficiently informed in how to respond to them.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 13/11/2020 | 14/09/2021 | 3  | 02/06/2021 |  | Implemented - Final Client Approved | regular reporting on cyber now provided to DIGC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Close | Superseded by 2023 review |
| 787 | Internal Audit | Cyber Security                           | 2019/20 | N/A | High   | Cyber Security Team                        | The Health Board consider the clear benefits of having a dedicated in-house Cyber security team in line with other Health Boards in Wales, in order to proactively monitor and respond quickly to any potential threats, implement and maintain Cyber Essentials plus and ISO27001 standards as well as managing the Health Boards statutory compliance with NIS-D responsibilities.   | ICT will work with Finance to push forward the Welsh Government proposals to establish Cyber Security Teams in each Health Board with appropriately funded resources to recruit experienced professionals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/12/2020 | 28/02/2023 | 12 | 15/02/2023 |  | Implemented - Final Client Approved | The Health Board has considered, supported and fully funded the establishment of an internal Cyber Security Team, which forms part of the controls and mitigations in response to the Cyber Security Corporate Risk CRR21-11, regularly updated and reported through to the PPPH Committee (Private Session). This supported the increase in funded establishment by 4 posts. 2 posts have been appointed to with the remaining 2 being actively recruited to.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Close | Superseded by 2023 review |
| 788 | Internal Audit | Managed General Practitioner Practices   | 2019/20 | N/A | Medium | Governance and oversight arrangements      | Management review, update and formally agree oversight governance arrangements with regards to Managed Practices across the Health Board to ensure accountability, responsibility and reporting lines are consistent and clearly defined.                                                                                                                                              | The Executive Director for Primary Care has asked that all managed practices come under a single line manager hosted by the East Area. Due to Covid-19 the proposal has stalled. As part of the move to a hosted management model the recommendation will be taken forward.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13/11/2020 | 31/01/2021 | 1  | 03/06/2021 |  | Implemented - Final Client Approved | Implemented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                           |

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| 793 | Internal Audit | NHS Wales Staff Survey – Delivering the Findings                         | 2019/20 | N/A     | High   | New Workforce Improvement Group (WIG)                                                                              | The WIG Terms of Reference are reviewed, updated accordingly and submitted for approval to the group/meeting to which it reports assurance. The WIG meeting receives regular progress updates from all divisions on their staff survey action plans.                                                                                                                                                                                               | WIG is being superseded by a structure of Strategic, Tactical and Operation workforce groups. The terms of Reference of the Integrated Operational Workforce Group (IOWG) has specific responsibility for Staff Engagement / Staff Survey Improvement as detailed below in the relevant sections extracted from the ToR : 2. Purpose 2.1 The Integrated Operational Workforce Group meetings will take place on a monthly basis within each area (East / Centre / West) the purpose of the meeting is to: scrutinise and review divisional staff survey action plans , drive improvements in workforce KPIs, specifically but not exclusively; y; and Staff engagement scores as measured by local surveys and by National Staff Survey . 3.1 The Integrated Operational Workforce Group meetings principal duties are: To oversee locality workforce KPIs, developing and enacting plans to ensure all are ‘ green ’ rated; and To oversee effective local staff engagement plans resulting in highly engaged workforce as evidenced by improved staff engagement scores in local and national surveys. 11. Inputs Agenda – Standing Items: Action Log (actions from previous meeting) Updates from Sub-Groups OD Occupational Health & Safety Workforce KPIs Staff engagement scores as measured by local surveys and by National Staff Survey Vacancy rates Recruitment timescales Sickness Absence rates Mandatory Training compliance rates PADR compliance rates Levels of non-core usage (Agency / Bank / Locum / Overtime) Any other Business Date of Next Meeting IOWG agenda now includes regular staff survey action plans progress updates as a standing agenda item.                                                                                                            | 13/11/2020 | 30/04/2021 | 2 | 02/06/2021 |  | Implemented - Final Client Approved | IOWG (Integrated Operational Workforce Groups) re-established                                                                                                                                                                                                                                                                                                                                                                                                             | Exec to review                     |                           |
| 794 | Internal Audit | NHS Wales Staff Survey – Delivering the Findings                         | 2019/20 | N/A     | High   | Divisional Action Plans scrutiny                                                                                   | All Divisional Directors provide assurance to the WIG that respective staff survey action plans are standard agenda items within their senior management team meetings.                                                                                                                                                                                                                                                                            | Senior Divisional management are required attendees at the newly formed Integrated Operational Workforce Group (IOWG) chaired by the Head of HR /Divisional Director for each area. The terms of Reference of the Integrated Operational Workforce Group (IOWG) has specific responsibility for Staff Engagement / Staff Survey Improvement. IOWG agenda now includes regular staff survey action plans progress updates as a standing agenda item. OD team leads have ensured there are local leads in West, Central, Estates & Facilities and Mental Health, with further work planned to develop the same process with a lead in the East. OD will ensure that Staff Survey Divisional leads are supported to enable regular reporting against their improvement plans through their local IOWG. HoHR will also support local divisional managers to ensure progress against improvement plans.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13/11/2020 |            | 0 | 09/11/2020 |  | Implemented - Final Client Approved | The Integrated Operational Workforce Groups are chaired by senior divisional management supported by Heads of HR. The IOWG includes staff survey/staff engagement as a standard agenda item. Progress against staff survey 2018 action plans are discussed along with updates on the new 2020 staff survey. Wider staff engagement issues are also discussed as a standard agenda item.                                                                                   | Exec to review                     |                           |
| 795 | Internal Audit | Recruitment                                                              | 2019/20 | N/A     | High   | Data quality EC & TRAC                                                                                             | For both EC and TRAC, Workforce & OD stipulate the format for recording alphanumeric fields; default the date recording, per date field, to the system date/time, thus removing issues of data quality and blank fields.                                                                                                                                                                                                                           | Changes have been made to the EC Portal to ensure that a reference can be made between the two systems. Linking the two is now built into the process and a question amended on Trac for greater clarity (EC question on Trac to state please only add the alphanumeric EC reference). Additional guidance produced and available on the intranet also available direct in Trac. This additional Guidance is to help users understand how to complete Trac and EC Portal.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20/11/2020 |            | 0 | 07/12/2020 |  | Implemented - Final Client Approved | Changes have been made to the EC Portal to ensure that a reference can be made between the two systems. Linking the two is now built into the process and a question amended on Trac for greater clarity (EC question on Trac to state please only add the alphanumeric EC reference). Additional guidance produced and available on the intranet also available direct in Trac. This additional Guidance is to help users understand how to complete Trac and EC Portal. | Evidence required to close action. |                           |
| 796 | Internal Audit | Recruitment                                                              | 2019/20 | N/A     | High   | EC process review                                                                                                  | The process for reviewing EC requests through the service/division are revisited. There may be an opportunity to remove steps so streamlining the EC approval process whilst maintaining robust internal control.                                                                                                                                                                                                                                  | An action plan has been developed to respond to all recommendations within this. A concurrent process of inputting Trac Vacancies at the point of the EC being raised is being deployed to reduce the overall burden for recruiting managers, from Resignation (including the overall EC Process) to Appointment. A full review of the end to end process has taken place thus removing unnecessary EC steps as appropriate. Inclusion of data within the Monthly Dashboard to highlight any specific delays. Monitor and review KPIs in line with agreed EC Process. Dashboard currently shows that for M&D staff across BCU the time to hire (notice date to authorisation start date) has fallen consistently from 130 days in April to 90 days in June. (July is showing as less than 50 days but this may be an anomaly as there were relatively few starters that month).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/01/2021 |            | 0 | 10/03/2021 |  | Implemented - Final Client Approved | 2 approval steps have now been removed. the recruitment teams actively support specialties to get vacancies on Trac in a timely manner.                                                                                                                                                                                                                                                                                                                                   | Evidence required to close action. |                           |
| 797 | Internal Audit | Environmental Sustainability Report                                      | 2019/20 | N/A     | Medium | Environmental Strategy                                                                                             | The Health Board should develop and approve an effective overarching corporate strategy to provide strategic oversight of the organisation's commitment to environmental sustainability.                                                                                                                                                                                                                                                           | The draft strategy will be completed by December 2019.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/12/2019 | 31/03/2022 | 7 | 23/02/2022 |  | Implemented - Final Client Approved | Carbon Trust appointed to develop the Health Board's 5 year de-carbonisation plan in response to WG's net zero target by 2030 for all public sector.                                                                                                                                                                                                                                                                                                                      |                                    |                           |
| 799 | Internal Audit | Statutory Compliance: Fire Safety                                        | 2019/20 | N/A     | High   | Site specific documentation                                                                                        | Management ensure a consistent approach is adopted across the Health Board to deliver the requirements laid out in the Fire Safety Policy are adhered to at all times.                                                                                                                                                                                                                                                                             | All outstanding actions within this section have previously been identified by the Fire Safety Management Group and are included within the existing improvement plans. Many of the risks were captured and shared through the 2018/19 Annual Fire Safety report. The localised contractual issues related to procurement challenges and have now been resolved and are complete. A programme has commenced to ensure all existing Fire Risk Assessments have been reviewed within the appropriate timeframe. Fire folders to be reviewed and a common template to be created for sites. A review of the way fire drills are undertaken and a programme created to ensure they are completed within recognised timeframes and recorded appropriately. Operational Estates Contractor 's guidance document to be reviewed to ensure fire safety is captured within the induction process. This will be the responsibility of the Project lead as defined under current CDM regulations. Albac mat training is undertaken as part of the induction programme for clinical staff and within their four -year refresher-training programme. Agree with the training department that all relevant staff receive the appropriate training in line with manufacturer 's guidance. It is proposed that a 'MICAD' system is purchased and implemented within the Health Board to act as a single repository for all site drawings including fire plans and updated within a timely manner once alterations have been made. (The total implementation period for this project is 18 Months and subject to recurring revenue support) This software development is being included within the procurement of the Health Boards six facet survey and is currently being tendered through shared services. | 01/04/2021 | 31/03/2022 | 2 | 03/03/2022 |  | Implemented - Final Client Approved | Recommendation completed                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Close                              | Superseded by 2024 review |
| 802 | Internal Audit | Quality Improvement Strategy                                             | 2020    | Limited | High   | Quality/Welcome Boards                                                                                             | Management ensure Quality/Welcome Boards are maintained in accordance with the operational procedure – Hospital and Area Directors of Nursing should routinely ensure they receive assurance that this information is up to date.                                                                                                                                                                                                                  | The supporting SOP for the ward welcome boards has been updated with clearer guidance for ward teams. The monitoring of the data displayed at ward level is an integral part of the ward accreditation process currently and will be monitored monthly via the revised Matrons Quality Audit about to be launched, 12 months post implementation of the monthly Ward Accreditation metrics completed by Ward Managers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 01/04/2020 | 30/09/2020 | 1 | 01/07/2020 |  | Implemented - Final Client Approved | Update received from the Corporate Quality Improvement Nursing Lead: The Matrons Quality Audit has been implemented from 1st July 2020, and as such, it is ahead of the previous implementation date. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience has confirmed that this recommendation can be closed as this recommendation has been implemented                                                           | Evidence required to close action. |                           |
| 808 | Internal Audit | Health and Safety                                                        | 2021    | N/A     | N/A    | Gap Analysis action plan                                                                                           | A full review of all work streams by the relevant owners within the gap analysis action plan is required thus providing the Health Board with an up to date action plan fit for purpose.                                                                                                                                                                                                                                                           | The Gap Analysis action plan will be fully reviewed and updated with new timescales for completion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 09/07/2021 |            | 0 | 12/09/2021 |  | Implemented - Final Client Approved | This action was completed and the GA action plan was updated - last updated 20.08.21 to be updated again by 20.09.21                                                                                                                                                                                                                                                                                                                                                      |                                    |                           |
| 809 | Internal Audit | Security                                                                 | 2021    | N/A     | High   | Finding - ISS.1 – 2005 Security Management Framework for NHS Trusts in Wales compliance. (Operating effectiveness) | 1: Corporate Health & Safety Management and Security Manager review the implementation of the Framework and align with the security plan, combining all gaps into one overarching implementation project/plan.                                                                                                                                                                                                                                     | 1: The security action plan has been reviewed and is currently under amendment. Checks against the Welsh Government Security Management Framework identified elements that were not included and additional actions are being written to ensure the action plan is comprehensive. The final action plan will be completed 01.04.21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 09/07/2021 |            | 0 | 16/08/2021 |  | Implemented - Final Client Approved | The action plan was fully reviewed and updated in line with the WG Security Management Framework. This was completed on 25.03.21 and the action plan is updated weekly. The Executives have approved a business case for the security management team for the next 12 months which allows for the remaining outstanding actions now to be progressed                                                                                                                      | Evidence required to close action. |                           |
| 810 | Internal Audit | Security                                                                 | 2021    | N/A     | High   | Finding - ISS.2 – Security Action Plan (Operating effectiveness)                                                   | 2: See Recommendation 1 ensuring gaps in implementation of the security action plan are embedded within the requirements of the Framework, including but not exhaustive the following: Crime prevention programme; Access to guidance; Competency and performance; and KPIs development and                                                                                                                                                        | 2: The security action plan has been reviewed and is currently under amendment. Checks against the Welsh Government Security Management Framework identified elements that were not included and additional actions are being written to ensure the action plan is comprehensive. The final action plan will be completed 01.04.21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 09/07/2021 |            | 0 | 30/06/2021 |  | Implemented - Final Client Approved | completed 25.03.21                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Evidence required to close action. |                           |
| 811 | Internal Audit | Violence and Aggression – Obligatory responses to violence in healthcare | 2021    | N/A     | High   | Provision of V&A Training                                                                                          | 1.1: The Health Board standardise delivery of all V&A training, through an adequately resourced service, ensuring all Health Board staff receive Module B & C training where a risk assessment and subsequent training needs analysis determines. To deliver training in a cost-effective way, consideration should be given to taking the training 'on the road' where the training package allows, thus reducing lost time for front-line staff. | 1.1: Training Needs Analysis to be completed for mandatory training - 31.07.21. 1.2: Finalise the training package in line with the All Wales NHS V&A Training and Information Scheme - 31.05.21. 1.3: Review and update all V&A templates - 30.06.21. 1.4: Upload V&A risk assessment templates on the intranet and update intranet pages - 30.06.21. 1.5: Implement a process to monitor risk assessments completed through Corporate health and Safety reviews and Self Assessments returned to the H&S team - 31.05.21. 1.6: SBAR to be completed to escalate the resource required to deliver training for Module C - 31.05.21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/07/2021 |            | 0 | 30/06/2021 |  | Implemented - Final Client Approved | A new training package has been written with all aspects from Module C under the new scheme are covered. Trial undertaken with positive feedback. Training dates have now been planned with the first training to take place on the 3rd of August                                                                                                                                                                                                                         | Evidence required to close action. |                           |
| 812 | Internal Audit | Violence and Aggression – Obligatory responses to violence in healthcare | 2021    | N/A     | High   | Obligatory response to violence in healthcare                                                                      | 2: The Health Board must fulfil all its duties in delivering and actively promoting the Obligatory Response.                                                                                                                                                                                                                                                                                                                                       | 2.1: Training schedule for department/ ward visits/ Teams meetings to be compiled - 31.05.21. 2.2: ORV to be captured in all H&S training slides delivered by the Team - 30.06.21. 2.3: Explore options for promotion through the internal staff intranet - 31.05.21. 2.4: Consultation with TU partners/H&S leads - 31.05.21. 2.5: Complete the schedule of police education training sessions - 31.05.21. 2.6: Education session to be arranged for Occupational Health following staff referrals due to V&A incidents - 31.05.21. 2.7: SBAR to be completed to update the Executives - 31.05.21. 2.8: Engage with the National campaign for promotional material once this has been established - 31.07.21. 2.9: Promote via the staff app/ staff bulletins/H&S newsletter - 30.06.21.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/07/2021 |            | 0 | 13/09/2021 |  | Implemented - Final Client Approved | Action completed, intranet updated, training in place. Action plan attached as evidence of progress                                                                                                                                                                                                                                                                                                                                                                       | Evidence required to close action. |                           |

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| 813 | Internal Audit | Violence and Aggression – Obligatory responses to violence in healthcare | 2021 | N/A | High   | Lessons Learnt                                                                | 3: The role of documenting lessons learnt rests with the investigating officer/line manager who should ensure lessons learnt are clear, concise and deliverable. The V&A Team should scrutinise lessons learnt and identify broader learning for sharing Health Board wide to reduce the risk of similar V&A incidents happening to staff.                                                                                                                                                                                                               | 3.1: Lessons learnt is a specific section on datix, a review of this will be undertaken to identify key elements of training required for staff, supportive guidance documents and risk assessment templates - 30.06.21. 3.2: Protecting staff from Violence and Aggression/Managers actions course to be written and implemented - 30.06.21. 3.3: RCA's for RIDDORs are reviewed and reported to the SOHSG. A RIDDOR review group is to be established - 30.06.21.                                                                                                                                                                                                | 06/07/2021 |            | 0 | 15/09/2021 |  | Implemented - Final Client Approved | A review of datix shows 73% of incidents have a clinical factor and a task specific group is being established to be led by Professor Lepping to explore the clinical model. A training package for managers to understand the Obligatory Response to Violence and actions to take following a Violence and Aggression (V&A) incident was written by the V&A team and course were initially arranged for July, August and September. These are now being extended and will be offered to all managers and those specifically in response following a Datix reported incident. Updated action plan attached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Evidence required to close action. |                           |
| 814 | Internal Audit | Violence and Aggression – Obligatory responses to violence in healthcare | 2021 | N/A | Medium | HS02 Procedure and Guidance Protecting Employers from Violence and Aggression | 4: HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is approved and issued as soon as practically possible.                                                                                                                                                                                                                                                                                                                                                                                                                   | 4.1: HS02 Guidance Protecting Employees from Violence and Aggression to be ratified at the Strategic Occupational Health and Safety Group 25.05.21 - 31.05.21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 06/07/2021 |            | 0 | 28/06/2021 |  | Implemented - Final Client Approved | Ratified at the Strategic Occupational Health and Safety Group 25.05.21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |                           |
| 815 | Internal Audit | Violence and Aggression – Obligatory responses to violence in healthcare | 2021 | N/A | Medium | Reporting of incidents                                                        | 5: All staff are reminded to report incidents of V&A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5.1: HS02 Guidance for Protecting Employees from Violence and Aggression details the process to report through Datix. Promotion of this further will be via the educational sessions and communications detailed in section 2 - 31.07.21                                                                                                                                                                                                                                                                                                                                                                                                                           | 31/07/2021 |            | 0 | 13/09/2021 |  | Implemented - Final Client Approved | Actions completed, staff advised to record and all datix incidents are now reviewed. Copy of the most up to date Security / V&A action plan attached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    |                           |
| 816 | Internal Audit | Engagement of interim appointments                                       | 2021 | N/A | High   | Interim Appointment governance                                                | Using available Office365 applications to apply control and automate steps, a full system review is undertaken to govern the recruitment of all interim appointments, thus removing the ability of individuals to engage interim staff without procurement, finance and workforce processes completed                                                                                                                                                                                                                                                    | Use of Office 365 is not appropriate for these purposes. However, an electronic process has been developed to support workflow, audit and reporting. Revised Standard Operating Procedure developed and subject to review and approval by Executive Team. Communication sent to agencies confirming the process and indicating payment of invoices will not be made if process not followed.                                                                                                                                                                                                                                                                       | 09/07/2021 |            | 0 | 08/09/2021 |  | Implemented - Final Client Approved | Revised SOP implemented and performance reporting in place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Close                              | Superseded by 2024 review |
| 817 | Internal Audit | Engagement of interim appointments                                       | 2021 | N/A | High   | Interim Appointment governance                                                | Using available Office365 applications to apply control and automate steps, a full system review is undertaken to govern the recruitment of all interim appointments, thus removing the ability of individuals to engage interim staff without establishment control, procurement, finance and workforce processes complied with. All engaging officers ensure they comply with the Standing Financial Instructions.                                                                                                                                     | Once the post has been approved, a purchase order will be raised prior to the engagement of the individual in order to comply with SFIs and appropriate guidance, together with the process will be issued across the organisation. A reminder to all staff about no purchase order, no pay will be issued by the end of April 2021. In addition, it has been agreed that a regular report will be submitted to RATS detailing engagement of senior interims against this process and compliance with the process.                                                                                                                                                 | 02/08/2021 |            | 0 | 08/09/2021 |  | Implemented - Final Client Approved | SOP implemented and performance reports submitted through Exec Team and RATS Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Close                              | Superseded by 2024 review |
| 818 | Internal Audit | Engagement of interim appointments                                       | 2021 | N/A | High   | Interim appointment review                                                    | The Executive Director of Finance considers whether the engagement to the post requires further investigation (Post 9) to determine whether the process followed was robust and delivered value for money                                                                                                                                                                                                                                                                                                                                                | The Executive Director of Workforce has undertaken a review of the engagement of the post (post 9) to examine the recruitment process and outcomes delivered. The findings have been shared with Internal Audit and the Executive Director of Finance. The findings from this review have informed policy development already in-train regarding appointment to interim positions and the Executive Director of Finance will consider whether the post requires any further investigation.                                                                                                                                                                         | 06/07/2021 |            | 0 | 11/08/2021 |  | Implemented - Final Client Approved | Confirmed with senior finance team that this recommendation has been implemented.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Close                              | Superseded by 2024 review |
| 821 | Internal Audit | Budgetary Control & Financial Reporting                                  | 2021 | N/A | Medium | Clear Scheme of Delegation                                                    | Divisions/Departments should ensure the Scheme of Delegation is up to date and only the latest version should be available on the intranet/internet. Finance should ensure any outdated links are removed and replaced with links to the new documents on the latest intranet site.                                                                                                                                                                                                                                                                      | The links will be redirected to the new intranet site and old version of the document will be removed as part of the process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/08/2021 |            | 0 | 26/07/2021 |  | Implemented - Final Client Approved | The recommendation has been implemented. All previous references have been removed from the intranet and new links have been established to the internet.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                           |
| 822 | Internal Audit | Budgetary Control & Financial Reporting                                  | 2021 | N/A | Medium | Authorised Virements                                                          | Finance Directorate should continue to develop the system in the identified areas for improvement, with a particular focus on the following areas: <ul style="list-style-type: none"> <li>Develop virement reporting functionality;</li> <li>Highlighting delays in the authorisation of virements;</li> <li>Implementing a system controlled segregation of duties, whereby the requestor cannot authorise the virement; and</li> <li>Ensuring the virements are directed to the correct authoriser based on the cost centre and subjective.</li> </ul> | The Financial Reporting team, with support from our IT colleagues, will continue to develop the e-virement process. We will explore the capabilities of the system to enforce segregation of duties between creation and approval, reminder e-mails for outstanding approvals, and the potential ability to create reports from the system. The enforced direction of virements to the correct authoriser based on cost centre and subjective authorisation is a much more complex as Oracle, which holds the approver hierarchy, and the e-virement system are both stand-alone systems, but we will explore the possibility of developing links to both systems. | 30/09/2021 | 31/03/2022 | 2 | 15/03/2022 |  | Implemented - Final Client Approved | The Finance Team has been considering with IM&T colleagues how the recommended changes can technically be made in the system. In March 2022, IM & T advised the portal system has a limited life span (maximum of two years) as the future strategy is to rebuild in a different application, it wasn't felt a good use of resources enhancing the system at this point.. The remaining enhancements and recommendations can be incorporated into the new system. In the interim period each recommendation has been revisited and the risk evaluated:- <ul style="list-style-type: none"> <li>a)Develop virement reporting functionality; Whilst formal reports cannot be extracted from the system, workarounds such as copy and paste to excel do allow some data to be extracted for evaluation. Also once the virement is converted to a budget upload file the budget upload file is available for inspection. The need to have workaround in its self does not present a risk, but does mean that breaches against the agreed process may not be picked up in a timely way. This risk can be mitigated by more detailed sample checking to ensure staff are following the agreed process.</li> <li>b)Highlight Delays in the authorisation of virements; IM &amp; T were able to introduce a serious of four reminder e-mails, and this coupled with a manual review and chase up on a regular basis has resulted in minimal delayed authorisation over the last couple of months.</li> <li>c)Implementing a system controlled segregation of duties, whereby the requestor cannot authorise the virement; The system allows the same requestor to authorise, as in accordance with the agreed guidance some transactions do allow self-authorisation (e.g. phasing). To evaluate the risk a sample of 50 virements were reviewed, of these 45 had no segregation</li> </ul> |                                    |                           |
| 823 | Internal Audit | Budgetary Control & Financial Reporting                                  | 2021 | N/A | High   | Reports addressed                                                             | All Budget Managers should ensure they comply with the requirements of the accountability agreement.                                                                                                                                                                                                                                                                                                                                                                                                                                                     | The 54% average is recognised as being low, however two areas will have influenced this :- <ul style="list-style-type: none"> <li>The sample was taken in the period when Covid would have impacted on the normal workload of managers.</li> <li>Some Managers will have accessed the financial information via either documents presented at meetings, or via shared screens over teams.</li> </ul> Action: In the 21/22 Budget Manager Accountability Agreement letter to CFO's being issued before the end of May and this issue will be referred to. A monthly report will be circulated via FLM to monitor access and check statements are being reviewed.    | 31/07/2021 | 30/09/2021 | 1 | 26/11/2021 |  | Implemented - Final Client Approved | Each CFO was approached to identify how many managers have access to financial information in a different format. 24% of managers obtain reports via a different format, either as well as reports via quickview or instead of quickview. In addition to this CFOs explained that many teams have group sessions with the relevant managers, where one user (often finance rep) will have the reports open on screen, or shared screen if working over teams, and the information is reviewed and validated jointly. In the main CFOs expressed confidence that the majority of information was reviewed on a regular basis, and one CFO confirmed that for a small number of managers which had not had recent contact with the finance team, the finance team were actively chasing for a review meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Close                              | Superseded by 2024 review |
| 824 | Internal Audit | Budgetary Control & Financial Reporting                                  | 2021 | N/A | Medium | Accountability Agreements                                                     | All cost centres are accounted for through a signed Accountability Agreement – Where officers do not sign, management should consider whether those officers are fulfilling the requirements as set out in their job description. The Budget Manager Handbook should be updated along with key contacts and updated                                                                                                                                                                                                                                      | Action: the 21/22 Budget Manager Accountability Agreement letter will be issued before the end of May. A weekly report will be produced for FLM to monitor how many Managers have authorised the statements, and corrective action will be taken to follow up with Managers on non-compliance. A review and update will also be carried out of the Budget Manager Handbook.                                                                                                                                                                                                                                                                                        | 31/07/2021 | 30/09/2021 | 2 | 27/10/2021 |  | Implemented - Final Client Approved | Actions were 100% complete on the 27/09/21.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                           |



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| 825 | Internal Audit | Budgetary Control & Financial Reporting                                   | 2021 | N/A | Low    | Questionnaire                                 | Finance to review the findings of the Questionnaire and undertake regular budget holder satisfaction surveys.                                                                                                                                                                                                                                                 | Action: a satisfaction questionnaire will be developed so we can review how satisfied Budget Holders are on a regular basis. E-learning training is currently under development and Managers will be signposted to this from a variety of sources, including the Budget Holders Handbook.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/11/2021 | 28/02/2022 | 2 | 03/03/2022 |  | Implemented - Final Client Approved | All actions have now been implemented.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |  |
| 826 | Internal Audit | Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices | 2021 | N/A | High   | Medical Device Alerts & Field Safety Notices  | The Health Board, in refreshing the Patient Safety Alerts and Notices Operational procedure broaden its scope to establish a 'one-stop' Alerts/Notices procedure. Consideration is given to combining all alerts and notices under the control of one Team, thus enabling assurance provision to relevant operational groups and Board Committees seamlessly. | Following identification of the issues prior to this report being received, and further to discussions between the Executive Director of Therapies and Health Sciences, Associate Director of Quality Assurance, Medical Physics Team, Risk Team and Patient Safety Team, this course of action was already being progressed. The Patient Safety Team have now taken over the management of all Alerts (PSA; PSN; FSN, MDA, MHRA and Internal Alerts), known collectively as Safety Solutions, as of 30 March 2021, with the exception of medication alerts which remain with Pharmacy due to different national process but they will be aligned with the new single process. A new process and flow chart has been created and shared with all Safety Solution Leads across BCU.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09/07/2021 |            | 0 | 30/03/2021 |  | Implemented - Final Client Approved | This action is complete - completed on 30 March 2021.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Evidence required to close action. |  |
| 827 | Internal Audit | Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices | 2021 | N/A | Medium | New Recommendation                            | Operational areas and divisions are reminded of the importance of sharing and discussing all Alerts and Notices in order that lessons learnt become embedded in day to day practice.                                                                                                                                                                          | The compliance return has now been amended to include confirmation that the actions were cascaded and discussed at the relevant operational and management team meetings. Minutes of the relevant meetings are to be embedded into the compliance return for evidence. The next alert received will include a reminder that all alerts should be discussed at the relevant operational management team meetings within the e-mail request and highlighting the amended compliance return.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 09/07/2021 |            | 0 | 21/04/2021 |  | Implemented - Final Client Approved | The compliance return has now been amended to include confirmation that the actions were cascaded and discussed at the relevant operational and management team meetings. Minutes of the relevant meetings are to be embedded into the compliance return for evidence. The next alert received will include a reminder that all alerts should be discussed at the relevant operational management team meetings within the e-mail request and highlighting the amended compliance return.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    |  |
| 828 | Internal Audit | Caldicott assessment                                                      | 2021 | N/A | Low    | Accuracy                                      | Consideration should be made to amending the submission or factoring in for future iterations.                                                                                                                                                                                                                                                                | IM5 – (Does the organisation have a strategy to ensure the correct NHS number is recorded for each active patient and that it is used routinely in clinical communications). The wording error has been acknowledged by the Deputy Patient Records & Digital Integration. The information submitted by the Health Records Service is in relation to the standards of record keeping as defined in the HR1 – Management of Patient Records Procedure. The Health Records Service does not have overall responsibility to ensure the correct NHS number is recorded for each active patient on all systems and that it is used routinely in clinical communications. Conversations are ongoing to establish ownership and responsibility of this requirement. Comments accepted. G6 – (restricting disclosure). Comments accepted. We will refer to the processes in place and review the score on the next submission. IM6 - (standardised paper records). The case notes for the acute records has been following a standard for many years, with any changes requested requiring an evaluation and decision from the Patient Records Group (this process if controlled by the Health Records Service). The Patient Records Group meetings will explore with the non-acute custodians the practicalities and appropriateness of adopting the same standard case note folder. The Health Records Service are also carrying out a baseline assessment of all other patient record types across BCU and this audit also carries out a random sample audit against their patient record type which looks at standards of record keeping against the HR1 – Management of Patient Records Procedure and the Welsh IG Toolkit. This is a project of work that will be carried out over this and the next financial year. Comments accepted - Work is ongoing which will be progressed through the Patient Records Group. We will reduce the score as necessary on the next submission if required. IM7 - (ID duplicate records). Unfortunately the report did not include the statement below from the Deputy Head of Digital Health Records: There is an existing procedure for the merger of duplicate case notes (HR7 – Merging Duplicate Case notes). HR1 is being reviewed and extended to cover commingling and rectification in line with Data Protection Legislation 2018, with the Good Record Keeping Training being updated to give guidance and signposting on these issues. Comments noted. IM8 (tracing records). The Health Records Service has completed the implementation of the iFIT RFID Intelligent Tracking Solution across the majority of patient record types. During this year a baseline assessment will be carried out of all patient records types across BCU which will ensure that they all using iFIT tracking or have a robust tracking solution in place. Comments noted. Overall Response. The results of the internal audit reflects the current position within the Health Board. The low risk areas of concern highlighted within the report have already been identified and are already incorporated into existing programmes of work. There is an expectation that we will be able to evidence the continuous improvements through the Information Governance Toolkit submission in March 2021. | 01/03/2022 |            | 0 | 08/02/2022 |  | Implemented - Final Client Approved | This recommendation is in relation to the underscore for Section G6. The rationale for this score has already been discussed with the Internal Auditor. The Caldicott Assessment had different levels to select based on the physical evidence you could locate to justify the level selected. Once you select the appropriate level, the system then automatically generated the score. The question asked was "Do mechanisms and guidelines exist to ensure that any decision taken by a patient or service user to restrict disclosure of their personal information is appropriately respected? Following discussions with Health Records Team, the Health Board were only able to provide physical evidence to select level b as per the below. There are also incidents recorded to evidence that whilst the guidance is in place, this was not being fully complied with due to the restrictions on the current clinical systems to fully restrict the information. a - No. b - Yes, the guidelines and procedures are freely available and all appropriate staff are aware. Partially correct. c - Yes, the guidelines and procedures are freely available and all appropriate staff are aware. Targetted training is provided to staff. d - Yes, the guidelines and procedures are freely available and all appropriate staff are aware; understanding is regularly evaluated. Policy, guidelines and casea are subject to regular review. Therefore once the appropriate level was selected as per the Caldicott Assessment descriptors, this generated the partial score. This was because we were unable to provide of targeted training or that this training was regularly evaluated for us to be able to select descriptors C or D. The Caldicott Assessment is so old and has not been updated nationally for many years. This year it is now obsolete and all NHS |                                    |  |
| 829 | Internal Audit | Disaster Recovery/Business Continuity Plan                                | 2021 | N/A | Medium | Informatics Business Continuity Documentation | Following relevant scrutiny and approval, Business Continuity Plans and Business Impact Analysis documentation to be issued as final. Informatics Business Continuity Leads review the Informatics BC SOP and ensure it is consistent with the newly revised Health Board Business Continuity Policy.                                                         | To update all Business Continuity Plans and Business Impact Analysis and gain approval of Informatics SMT. Work with DIGC on an assurance review for Business Continuity compliance to be part of the Assurance Report on an annual basis. Review and update the Informatics BC SOP so that it is aligned to the Health Board Business Continuity Policy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/06/2021 | 23/03/2022 | 6 | 23/03/2022 |  | Implemented - Final Client Approved | All Business Continuity Plans have been completed and reviewed by Informatics SMT on the 23rd March 2023.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    |  |
| 830 | Internal Audit | Disaster Recovery/Business Continuity Plan                                | 2021 | N/A | High   | Testing Exercises and Lessons Learned         | Informatics management ensure that controls are in place to meet policy and legislative requirements. Programme of annual BC Plan testing and debrief / lessons learned to be documented and retained.                                                                                                                                                        | Develop a scope and exercise for a single service exercise as a pilot. Arrange a BC Plan Exercise for the whole service* (Note: Due to the priority level we would hold this sooner but would want to do this as a live event with all key individuals in a room to gain maximum learning)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/10/2021 | 01/04/2022 | 4 | 01/04/2022 |  | Implemented - Final Client Approved | Business Continuity Exercise took place on 1/4/22 and lessons learnt were captured during the meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Evidence required to close action. |  |
| 831 | Internal Audit | Disaster Recovery/Business Continuity Plan                                | 2021 | N/A | Medium | Business Continuity Leads Training            | Informatics management ensure all Business Continuity Leads attend regular training.                                                                                                                                                                                                                                                                          | Business Continuity Leads will attend training when provided by the BCUHB Business Continuity Team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01/12/2021 |            | 0 | 30/11/2021 |  | Implemented - Final Client Approved | 8 members of staff across the services have now attended the Business Continuity Training. Further staff will attend once the training has been planned.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |  |
| 832 | Internal Audit | Disaster Recovery/Business Continuity Plan                                | 2021 | N/A | Medium | New Recommendation                            | Chief Information Officer considers the importance of Informatics engagement and representation at key Business Continuity meetings.                                                                                                                                                                                                                          | The CIO will ensure a representative attends at the Civil Contingencies Group and reports back to the Informatics SMT. Attendance will be reviewed at SMT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17/02/2021 |            | 0 | 26/02/2021 |  | Implemented - Final Client Approved | The CIO will ensure a representative attends at the Civil Contingencies Group and reports back to the Informatics SMT. Attendance will be reviewed at SMT. In addition BCP updates are scheduled into the Assurance and Improvement Service Cycle of Business for December.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |  |
| 835 | Internal Audit | Environmental Sustainability Report                                       | 2021 | N/A | Medium | Environmental Strategy                        | The Health Board should develop and approve an effective overarching corporate strategy to provide strategic oversight of the organisation's commitment to environmental sustainability.                                                                                                                                                                      | Estates will develop an environmental sustainability strategy using the design for "life framework".                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01/07/2021 | 31/12/2021 | 1 | 26/11/2021 |  | Implemented - Final Client Approved | Action Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |  |
| 836 | Internal Audit | Control of Contractors                                                    | 2021 | N/A | High   | Contractors Safety Guidance                   | A Health Board Standard Operating Procedure and should be developed to encompass the management of external contractors, this would state the relevant responsibilities of BCUHB personnel, including the differing departments who would be able to use contractors.                                                                                         | Estates and Facilities have a divisional Contractor's Safety Guidance Document (Standard Operating Procedure). This SOP was implemented in 2018 and following the audit review the SOP will be updated to include the actions contained within the recommendations of this audit. The Contractors safety Guidance Document (SOP) is available through the intranet under the Estates and Facilities section.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 09/07/2021 | 30/01/2022 | 2 | 26/11/2021 |  | Implemented - Final Client Approved | This action has now been implemented and the document to support has been attached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Evidence required to close action. |  |
| 837 | Internal Audit | Control of Contractors                                                    | 2021 | N/A | High   | H&S Gap Analysis                              | Operational Estates and Informatics ensure that required management actions to the H&S Gap Analysis Report, concerning the Control of Contractors are addressed.                                                                                                                                                                                              | Operational Estates and Informatics have developed a 2 stage operational procedure to ensure that management of contractors is compliant during the installation of data cabling. Phase 1 Implementation of an interim management procedure between Operational Estates and Informatics for the management of IMT Data cabling. Phase 2 As part of Estates and Facilities (Health and Safety and Statutory Compliance Resources Business Case), funding has been requested to progress the interim arrangement to permanent based on resource requirement. (The Business Case has been submitted as part of Estates and Facilities cost pressures for financial planning 2021-2022. The Director of Estates and Facilities / Chief Information Officer through the Head of Operational Estates and Data Communications Manager have agreed the following actions: Phase 1 – Completion by 30th April 2021 Phase 2 – Completion by 31st May 2021 (Subject to 2021-2022 budget setting process)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 09/07/2021 | 01/01/2022 | 2 | 26/11/2021 |  | Implemented - Final Client Approved | Implemented a safe system of work between Operational Estates and IMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Evidence required to close action. |  |
| 838 | Internal Audit | Control of Contractors                                                    | 2021 | N/A | Medium | Monitoring & Reporting of Contractors         | Formalise monitoring and reporting of contractor performance, noting satisfaction with delivery of work including any breaches of Health & Safety or other issues recorded on Datix                                                                                                                                                                           | As part of the review of the Contractors Safety Guidance Document (SOP) an addition section will be include to address monitoring and reporting of contractor performance (KPI's). This will be taken from the NHS Shared Services Procurement tender documentation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 09/07/2021 | 24/01/2022 | 4 | 26/11/2021 |  | Implemented - Final Client Approved | action implemented with supporting documentation included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    |  |
| 839 | Internal Audit | Statutory Compliance: Water Safety                                        | 2021 | N/A | High   | Governance Accountability Arrangements        | Policy requires a full review in respect of Roles, Responsibilities, Contact Details, and Key Appointed Roles. Reinstatement of Local Water Management sub-groups in accordance with TORs.                                                                                                                                                                    | Recommendation 1 Operational Estates are updating the Policy for the Management of Safe Water Systems (ES02) following internal audit recommendations and Corporate Health & Safety Audit review. Recommendation 2 The Health Board in line with HTM compliance has appointed an Authorising Engineer – Water Safety. This role is provided through NHS Wales Shared Services – Specialist Estates Services Pan Wales. Specialist Estates Services are currently recruiting to this role following the departure of the current post holder. Recommendation 3 In line with ES02 Terms of Reference for Local Water Safety Sub-Groups are in place. The frequency and attendance and escalation will be reviewed as part of the updated Policy for the Management of Water Systems.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30/06/2021 |            | 0 | 02/06/2021 |  | Implemented - Final Client Approved | recommendations have all been actioned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Evidence required to close action. |  |

|      |                |                                                               |         |            |        |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |            |   |            |  |                                       |                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                                                 |
|------|----------------|---------------------------------------------------------------|---------|------------|--------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|------------|---|------------|--|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------|
| 840  | Internal Audit | Statutory Compliance: Water Safety                            | 2021    | N/A        | High   | Water Safety Plan                                                                    | Water Safety Plan requires a full review to identify weaknesses as well as to ensure that control measures are in place to conform with the Welsh Health Technical Memorandum (WHTM) 04-01 and HSG274                                                                                                                                                                                                                                                                                                             | Operational Estates have appointed external consultants from Clearwater Technology Ltd to update the current Health Board Water Safety Plan to include the risks identified – Policy, Training and Risk Assessments. In compliance with WHTM 04-01 and HSG274                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30/06/2021 |            | 0 | 02/06/2021 |  | Implemented - Final Client Approved   | Actions addressed                                                                                                                                                                                                                                                                                                                                                                      | Evidence required to close action. |                                                                 |
| 841  | Internal Audit | Statutory Compliance: Water Safety                            | 2021    | N/A        | Medium | Training                                                                             | Complete a training needs analysis to ensure all relevant staff who require Water Hygiene’ training and other appropriate training have been identified                                                                                                                                                                                                                                                                                                                                                           | As part of Operational Estates PADR Programme, a bespoke training matrix has been developed for staff identified as requiring specific Water Hygiene Training.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30/04/2021 |            | 0 | 20/05/2021 |  | Implemented - Final Client Approved   | Water Hygiene training developed and Purchase Order raised for Ccompetent Person training which includes water hygiene                                                                                                                                                                                                                                                                 |                                    |                                                                 |
| 842  | Internal Audit | Statutory Compliance: Water Safety                            | 2021    | N/A        | High   | Contingency Plan                                                                     | Ensure that plans are in place for the supply and distribution of alternative safe water including annual testing as per policy ES02 – Policy for the Management of Safe Water Systems.                                                                                                                                                                                                                                                                                                                           | Operational Estates have reviewed the water supply contingency planning arrangements for all three acute sites. Ysbyty Glan Clwyd – Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority (Welsh Water / Dwr Cymru). The infrastructure is tested annual as part of the a programme of tests incorporated within the Fire Hydrant testing schedule. Ysbyty Gwynedd - Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority (Welsh Water / Dwr Cymru). A Planned Preventative Maintenance programme will be developed to ensure annual testing of outlet will be carried out. Wrexham Maelor Hospital - Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority (Hafen Dyfrdwy) the fill point is located adjacent the main water storage. Planned Preventative Maintenance programme will be developed to ensure annual testing of outlet will be                                                                                                                                                                                                            | 30/04/2021 |            | 0 | 20/05/2021 |  | Implemented - Final Client Approved   | Contingency Plan in plan across all 3 acutes site with local water authority. Action Card to implement plan will form part of the new Water Safety Plan                                                                                                                                                                                                                                | Evidence required to close action. |                                                                 |
| 843  | Internal Audit | Governance Arrangements Mental Health & Learning Disabilities | 2021    | N/A        | High   | Divisional governance arrangements                                                   | The Lead Executive Director for Mental Health reviews the governance and management structure and whether it remains fit for purpose.                                                                                                                                                                                                                                                                                                                                                                             | The Division has reviewed its Governance and Accountability Framework which is aimed at setting out the framework within which it operates. It is a key internal governance document for the Division and its purpose is to maximise transparency efficiency and accountability regarding how the Division is run. The framework sets clear expectations on standards, roles, accountabilities and responsibilities across the Division. The Divisional Senior Leadership Team meet weekly. The Membership and Terms of Reference (x4) for this group have been developed to be aligned to the business of the day – Quality, Safety and Experience; Finance and Performance; Clinical Advisory Group; Business. The meetings will receive Division wide reports relevant to that particular meeting and in accordance with the agreed cycle of business and meetings will focus on a specific business function. Agenda and supporting documents will be submitted aligned to the meeting schedule. The Framework has been approved by the Divisional Senior Leadership Team and is working towards full implementation.                                                                                                                      | 31/03/2021 | 31/05/2021 | 1 | 19/05/2021 |  | Implemented - Final Client Approved   | See update status from 19.05.2021 for narrative.                                                                                                                                                                                                                                                                                                                                       | Evidence required to close action. |                                                                 |
| 844  | Internal Audit | Governance Arrangements Mental Health & Learning Disabilities | 2021    | N/A        | High   | Psychological Services                                                               | The Health Board considers whether all Psychological Therapy Services remain appropriately supported within the Division or become hosted/stand alone service.                                                                                                                                                                                                                                                                                                                                                    | MHLD acknowledge there is a need to re-engage with the Psychology workforce. A key priority will be to ensure there is a Head of Psychology in post as part of the Senior Leadership Team to lead engagement with Psychology colleagues and determine clear proposals for the delivery of psychological therapies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/12/2021 |            | 0 | 04/01/2022 |  | Implemented - Final Client Approved   | Head of Psychology has now been in place within the Division since 19.07.2021 and is fully implemented into the Divisional Senior Leadership Team working on key priorities including Psychological Therapies.                                                                                                                                                                         | Evidence required to close action. |                                                                 |
| 845  | Internal Audit | Governance Arrangements Mental Health & Learning Disabilities | 2021    | N/A        | High   | Together for Mental Health Strategy                                                  | The Health Board revisits the Strategy as a matter of urgency to ensure it remains relevant in delivering and supporting Mental Health services in North Wales.                                                                                                                                                                                                                                                                                                                                                   | The principles of Together for Mental Health and Healthier Wales remain the strategic focus for delivery of Mental Health and Learning Disability services in North Wales. In line with the recommendation in this report, MHLD will undertake a review of the current interpretation and refocus to ensure services can respond appropriately to demand. MHLD will ensure there is a robust process established to ensure monitoring and achievement of key milestones.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/03/2022 |            | 0 | 16/05/2022 |  | Implemented - Final Client Approved   | Hilary Owen provided an update on 11.04.2022                                                                                                                                                                                                                                                                                                                                           | Evidence required to close action. |                                                                 |
| 847  | Internal Audit | Mental Health Approved Clinicians - Governance                | 2021    | N/A        | Medium | Oversight and Reporting                                                              | Management to review the appropriateness of the current arrangement. To maintain independence, objectivity, and avoid conflicts of interest the Approval Team should not be involved in operational and / or workforce related decisions outside their remit.                                                                                                                                                                                                                                                     | Recommendation accepted and agreed that the All Wales Approvals Unit Staff will not be involved in any future operational and/or workforce decisions outside their remit and accordingly will cease reporting to the Mental Health Act Committee. Accordingly, the amendments required to the Terms of Reference of the Committee will be addressed as part of the Governance Review being undertaken by the Interim Director of Governance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10/05/2021 |            | 0 | 25/06/2021 |  | Implemented - Final Client Approved   | The Team were recently informed by Assistant Director - Deputy Board Secretary that they are no longer required to attend the Mental Health Act Committee meetings. However, they are still required to provide reports for information purposes.                                                                                                                                      |                                    |                                                                 |
| 1096 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre               | 2016/17 | N/A        | Medium | Adviser performance                                                                  | The UHB will assess the performance of both the contractor and contract administrator as a part of the post project evaluation.                                                                                                                                                                                                                                                                                                                                                                                   | Noted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/05/2017 | 31/12/2019 | 6 | 23/12/2019 |  | Implemented - Final Client Approved   | Gateway 5 review completed in October 2019, assessment rated as GREEN.                                                                                                                                                                                                                                                                                                                 |                                    |                                                                 |
| 1100 | Internal Audit | Blaenau Ffestiniog Primary Care Resource Centre               | 2016/17 | N/A        | Medium | Adviser appointments                                                                 | Terms and conditions of appointment will be completed for all external advisers appointed at UHB projects in line with Standing Financial Instructions.                                                                                                                                                                                                                                                                                                                                                           | We have sought clarification following the comments raised on the Tywyn scheme. Our understanding, and intention, was that there should be a single contract for each framework with call off via a simplified order for each project. However in establishing the frameworks NWSSP-Procurement implemented the standard NHS Wales conditions. With respect to this project your report acknowledges that the consultants had accepted the framework terms and conditions and an implied contract therefore existed. The risk to the HB was therefore mitigated to a certain extent and the overall risk comparatively low. It should be noted that the HB are currently in the process of refreshing the frameworks and will address this issue.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/05/2017 | 30/04/2019 | 4 | 30/04/2019 |  | Implemented - Final Client Approved   | New framework appointments approved by F+P committee incorporating revised contractual arrangements.                                                                                                                                                                                                                                                                                   |                                    |                                                                 |
| 1255 | Internal Audit | Upholding Professional Standards in Wales                     | 2021    | Reasonable | Medium | Matter Arising - ISS.1 - UPSW reporting to Board/Committee (Operating effectiveness) | To strengthen compliance with UPSW requirements:<br>• The Designated Board Members (DBM) are noted as co-authors of the UPSW report to Committee (as they formally agree the report as part of the Joint Case Review meetings).<br>• The RATS Committee Terms of Reference are updated to include a DBM as a formal Member of the Committee, thus providing independent assurance to Committee/Board on the UPSW process.<br>• The Medical Director and/or Deputy Responsible Officer are formally invited to the | Joint Case Review meetings to include Executive Medical Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 31/10/2021 |            | 0 | 30/11/2021 |  | Implemented - Final Client Approved   | Updated terms of reference for RAts committe. – the UPSW co-authorship element was implemented at the last R&TS meeting in October and I have made the required terms of reference amendments – which are going to the R&TS meeting this Thursday 2.12.21. Approval at 14/12/21 audit committee. Medical Director/Deputy Responsible Officer (Evan Moore) chairs case review meetings. |                                    | Not categorised by IA                                           |
| 1256 | Internal Audit | Upholding Professional Standards in Wales                     | 2021    | Reasonable | Medium | Matter Arising - ISS.1 - UPSW reporting to Board/Committee (Operating effectiveness) | To strengthen compliance with UPSW requirements:<br>• The Designated Board Members (DBM) are noted as co-authors of the UPSW report to Committee (as they formally agree the report as part of the Joint Case Review meetings).<br>• The RATS Committee Terms of Reference are updated to include a DBM as a formal Member of the Committee, thus providing independent assurance to Committee/Board on the UPSW process.<br>• The Medical Director and/or Deputy Responsible Officer are formally invited to the | RaTS Committee Terms of Reference to be updated reflecting the addition of the Designated Board Member as a member of the Committee. This will be undertaken and submitted to the October RaTS Committee for approval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/10/2021 |            | 0 | 30/11/2021 |  | Implemented - Final Client Approved   | Updated terms of reference for RAts committe. – the UPSW co-authorship element was implemented at the last R&TS meeting in October and I have made the required terms of reference amendments – which are going to the R&TS meeting this Thursday 2.12.21. Approval at 14/12/21 audit committee. Medical Director/Deputy Responsible Officer (Evan Moore) chairs case review meetings. |                                    | Not categorised by IA                                           |
| 59   | Internal Audit | Risk Management                                               | ?       | Reasonable | Medium | Strategic Objectives                                                                 | The Health Board revisits its strategic priorities, setting objectives that are measurable by a set timeline. Further review of its completion to ensure aspects identified within the findings around risk appetite/target risk and controls etc.                                                                                                                                                                                                                                                                | The BAF continues to evolve with the engagement and support of the full Board. With the refresh of ‘Byw’n iach, Aros yn iach/Living Healthier, Staying Well’ and all underpinning strategies, the Board will need to ensure a greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. This will be undertaken during the course of the year, ensuring that clearly articulated and measurable objectives are set, for achievement within a specific timeline. A review of the risk appetite/target risk score was undertaken at a Board Workshop on 27th April and further review/refinement will continue linked to the refresh of ‘Byw’n iach, Aros yn iach/Living Healthier, Staying Well’ as we move through the year.                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/03/2022 | 30/03/2024 | 2 |            |  | Implemented - Partial Client Approved | Revised BAF approved by Board on 4th August 2022                                                                                                                                                                                                                                                                                                                                       | Exec to review                     | Wouldn't look at this as reasonable report and medium objective |
| 146  | Internal Audit | Maternity Cross-Border Arrangements                           | 2021    | Reasonable | Medium | Matter Arising 3 – Escalation of issues (Operation)                                  | Women’s Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.                                                                                                                         | • SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and present to the Health Board’s, Chief Executive Officer on 22/10/2021. • Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board’s Chief Executive Officer, for the attention of Cheshire CCG’s Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences to BCUHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation Trust. • Update on actions taken by the Women’s Division, in respect of the ongoing quality assurance concerns in the Maternity Service provided at the Countess of Chester, presented at the Women’s Executive Accountability meeting on 5/11/21 and at Corporate PSQ on 9/11/21. • Quality and Safety Audits and Assurances required during a pandemic and when formal contract management reporting resumes, to be formally and agreed with the Countess of Chester Provider Team on 24/11/21. | 31/12/2021 | 31/05/2024 | 9 |            |  | Implemented - Partial Client Approved | Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings.                                                                                                                                                                          | Exec to review                     | Wouldn't look at this as reasonable report and medium objective |



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| 147 | Internal Audit | Maternity Cross-Border Arrangements                                  | 2021    | Reasonable | High   | Matter Arising 4 - Finance and Contracting Arrangements (Operation)     | The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: • Contracting to share monthly data with Women's to enable periodic review and reconciliation. • The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. • Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.                                                                       | • NHS E Guidance issued in response to the Covid 19 (March 2020 extended for 2021/22) pandemic which Welsh Government has adopted, stood down the requirement for a formal signed contract and contract management and reporting requirement, these will however be re-established once that guidance changes • Despite the guidance BCUHB Contracting Team has continued to meet with providers and data has been continued to be received during the pandemic. • COCH implemented a new patient system in July 2021, there have been difficulties with the implementation which has resulted in BCUHB not receiving regular reports. This has been raised at meetings with COCH, formal correspondence has now been sent by the December 2021 Director of Midwifery and Women's Services. Associate Director of Contracting Maternity Cross-Border Arrangements Appendix A NWSSP Audit and Assurance Services 17 Contracting Team and a formal action plan requested for resolution. • Activity data will continue to be validated for responsible commissioner and undertakes a series of validation checks regarding tariff and coding. • Contracting to share monthly data with Women's to enable periodic review and reconciliation where queries arise these will be raised through the contract process once re-established formally by NHS England and Welsh Government and if required Clinical Audits will be pursued. • Contracting have built links to Cheshire CCG as the lead commissioner for the main acute services at Countess of Chester and any significant assurance reports are now shared with the Health Board. • BCUHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. • Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. • The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUHB whilst working outside of normal contracting arrangements, during a pandemic. | 31/12/2021 | 31/05/2024 | 3 |            |            | Implemented - Partial Client Approved | Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings. | Exec to review |                                                                        |
| 154 | Internal Audit | Establishment control – Leaver management                            | 2021    | Limited    | High   | Matter Arising 1 - Operational management compliance (Operation)        | Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to by operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badge; and Network access is revoked.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | The Workforce Performance and Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation. The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager, however, ESR will serve as the prompt and workforce teams can monitor and escalate if compliance is not adhered to. The specific actions will be: 1. To advise the NWSSP Team, wider stakeholders i.e., Finance, HR that with effect from the 1 February 2022 the team will be requesting all future agenda for change staff terminations to be completed via ESR Self Service. 2. Issue a BCU wide communication to advise that with effect from the 1 February 2022 all agenda for change staff terminations must be completed via the ESR Self Service system. 3. Initiate a mass upload from IBM to add against each staff member a minimum property list of ID Badge and IT equipment/Network access credentials. 4. ESR function actioned so that a notification is sent of individual staff terminations to specified colleagues/groups. This will be piloted with IT and Security to ensure the notifications are received with the relevant information i.e.: employee leaving date with a view to stop the monthly leavers report issued to IT as terminations will be notified in real-time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31/01/2022 | 31/07/2024 | 5 |            |            | Implemented - Partial Client Approved | No 4 was piloted but did not work for IT teams, this was escalated via IT to a national group who is looking at a solution for the IT element of this.                                                        | Exec to review |                                                                        |
| 155 | Internal Audit | Establishment control – Leaver management                            | 2021    | Limited    | Medium | Matter Arising 2 – Leaver data provided to areas / departments (Design) | Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas/departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce and OD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | There are four interventions to assist with supporting the wider leaver management reporting process: 1. The monthly production of the ESR Leavers Report compared to the ESR Change Event Log by Division. This will highlight the number of leavers terminated in ESR after the leaving date, this will be grouped by month for high level numbers. 2. The monthly review of Establishment Control requests which highlight the EC request is relating to a team member being replaced. The check to be completed will be comparing the team member noted on the EC request with the ESR Leavers Report and follow up action with the EC requestor regarding why the team member hasn't moved departments or been terminated. 3. Both interventions above will ensure that non-compliance reporting is more targeted. The enhanced reports will be included in the monthly exception reports and shared with Heads of HR and with relevant Senior Leadership Teams. Each quarter the report will be aggregated and will include details of the supervisors who are repeat offenders. 4. Where there is a lack of compliance training and support will be put in place in conjunction with IT and IG to ensure managers are fully equipped to carry out the actions required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/01/2022 | 30/06/2024 | 2 | 28/02/2022 | 30/08/2023 | Implemented - Partial Client Approved | This action has been implemented. It was not signed off earlier as it had dropped off the owners log due to a technical error with the system                                                                 | Exec to review |                                                                        |
| 619 | Internal Audit | Maternity Cross-Border Arrangements                                  | 2021    | Reasonable | High   | Matter Arising 4 - Finance and Contracting Arrangements (Operation)     | The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: • Contracting to share monthly data with Women's to enable periodic review and reconciliation. • The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. • Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.                                                                       | • COCH implemented a new patient system in July 2021, there have been difficulties with the implementation which has resulted in BCUHB not receiving regular reports. This has been raised at meetings with COCH, formal correspondence has now been sent by the December 2021 Director of Midwifery and Women's Services. Associate Director of Contracting Maternity Cross-Border Arrangements Appendix A NWSSP Audit and Assurance Services 17 Contracting Team and a formal action plan requested for resolution. • Activity data will continue to be validated for responsible commissioner and undertakes a series of validation checks regarding tariff and coding. • Contracting to share monthly data with Women's to enable periodic review and reconciliation where queries arise these will be raised through the contract process once re-established formally by NHS England and Welsh Government and if required Clinical Audits will be pursued. • Contracting have built links to Cheshire CCG as the lead commissioner for the main acute services at Countess of Chester and any significant assurance reports are now shared with the Health Board. • BCUHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. • Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. • The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUHB whilst working outside of normal contracting arrangements, during a pandemic.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 31/12/2021 |            | 0 |            |            | Implemented - Partial Client Approved | Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings. | Exec to review |                                                                        |
| 645 | Internal Audit | Roster management                                                    | 2019/20 | N/A        | Medium | Policies and Procedures                                                 | 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. Draft SOP needs to be approved and activated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 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 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. Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/07/2022 | 31/08/2022 | 1 | 14/12/2022 |            | Implemented - Partial Client Approved | Revised policy is now live with all relevant amendments enacted, the issue around breaks is now being managed by senior corporate nursing leads.                                                              | Exec to review | Wouldn't look at this as Assurance Not Applicable and medium objective |
| 646 | Internal Audit | Roster management                                                    | 2019/20 | N/A        | High   | Submission of timesheets by agencies                                    | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Formal letter to be issued to all agencies from Executive Director of Workforce & Organisational Development 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 Training sessions to be held again with Heads of Nursing, Matrons and Ward Managers to ensure understanding of requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/06/2022 | 30/09/2022 | 1 | 14/12/2022 |            | Implemented - Partial Client Approved | All original actions and further actions have now been completed                                                                                                                                              | Exec to review |                                                                        |
| 647 | Internal Audit | Roster management                                                    | 2019/20 | N/A        | High   | Implementation of 1 hour breaks                                         | 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. 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. | (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. Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care Revised SOP approved by People & Culture Executive Delivery Group and implemented                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/08/2022 | 30/09/2022 | 1 | 14/12/2022 |            | Implemented - Partial Client Approved | All actions have been implemented as per the action plan.                                                                                                                                                     | Exec to review |                                                                        |
| 73  | Internal Audit | Performance measure reporting to the Board – Accuracy of information | 2021    | Reasonable | Medium | Standard Operating Procedure                                            | Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Ensure Risk Stratification controls and procedures are formally documented.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | The RTT 26 Week Pathways Standard Operating Procedure is out for consultation and awaiting response from stakeholders. Previous feedback comments are being fed into the document and once all responses are reviewed the Standing Operating Procedure will follow the official sign off route via the Planned Care Board and Planned Care Transformation Group. The Head of Ambulatory Care post once filled will be responsible for owning and implementing the Standing Operating Procedure as best practice across BCUHB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 02/08/2021 | 30/06/2024 | 6 | 04/10/2022 |            | Started                               |                                                                                                                                                                                                               | Close          | Superseded - Performance in plan for 2024/25                           |

|     |                |                                                                      |      |            |        |                                                          |                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |            |    |            |            |                           |           |                |                                              |
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| 123 | Internal Audit | Procurement: Contract Management and Single Tender Waivers           | 2021 | Reasonable | Medium | E waiver system                                          | 3.1: Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met.                                                                                                                                                                                                                                | 3.1: We will investigate the possibility of updating the eWaiver system (as part of the 365 redesign) to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31/03/2022 | 31/12/2023 | 9  |            |            | Started                   | No update | Close          | Superseded by Procurement review.            |
| 57  | Internal Audit | Quality Improvement Strategy                                         | 2020 | Limited    | High   | Reporting progress of Quality Improvement Strategy (QIS) | For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: Is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan. | The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones, that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01/08/2020 | 31/03/2024 | 12 |            |            | Uncategorised on TeamMate |           | Exec to review | Likely superseded by Quality Framework       |
| 72  | Internal Audit | Performance measure reporting to the Board – Accuracy of information | 2021 | Reasonable | Medium | Reporting Accuracy                                       | Whilst we recognise that first issue above was likely the result of a typing error, management must ensure that all data reported is accurate. To ensure consistency and transparency, changes to reporting methodology should be noted in the report and communicated to the reader.                                                                            | Information reported to the Board in the Quality and Performance (Q&P) reports is currently extracted from a number of different data sources. Narrative to support the data is a combination of analysis by the Divisional/Programme leads and Performance Team Heads of Performance and Director of Performance. The current process is labour intensive and time consuming, the time between data being available and deadlines for producing the reports/completing the necessary internal governance clearance significantly limits the ability of the Performance Team to undertake quality assurance both in relation to the accuracy of the data included in each report as well as consistency between reports over time. The Board has requested the development of a new Integrated Quality and Performance Report (IQPR), this presents an opportunity to address the issues that are curtailing QA processes as well as to improve the content of the reports to ensure that the needs of the Board and subcommittees are met. Changes proposed include: Rationalising and automating the process of data collation and reporting - This will be supported by a process map of the current arrangements, which will enable the Health Board Informatics Team to develop a single performance data set. The Performance Team will work with the system developers in Informatics to harness Business Intelligence software with the aim of automating production of the 'front end' Board and Public facing reports. Once completed this new process should release Performance Team capacity to undertake detailed analysis of the information moving from performance reporting to performance monitoring and management, and should also provide more time to complete QA checks. Clear methodology for identifying areas of concern - The intention is to implement an assurance and risk scoring system that can be applied to each key metric (national and local) as well as the actions/outcomes identified in the Health Board Annual Plan. This will highlight the areas of greatest risk and/or lowest assurance which need to be brought to the attention of the Board. Additions and removals of items reported - Level of risk and assurance will change over time as a result of external factors as well as action taken by the service. The new IQPR will require a more dynamic approach to the items reported. It is recognised that the reasons for additions/removal of items from the report need to be open and transparent. It is intended that the new IQPR and the current reports, which will need to continue until the new report is in place will include a section where additions, removals and reasons for these changes are recorded. With regards to the development of the new IQPR, a Board workshop session took place on 27th April 2021 to discuss requirements. A plan comprising report specification and timescale will be produced for consideration by the CEO, Chairman and Executive Team in June 2021. | 31/07/2021 | 31/12/2022 | 5  | 15/08/2021 | 22/08/2023 | Uncategorised on TeamMate |           | Close          | Superseded - Performance in plan for 2024/25 |

TEAMMATE UPDATE - 2022-2023 RECOMMENDATIONS

APPENDIX 6 - INTERNAL AUDIT - CLOSED - VERIFIED

Sorted by category

| ID  | Internal Audit/<br>Audit Office | Report Title                                                         | Year | Assurance Level | Priority | Recommendation Title                                                | Recommendation                                                                                                                                                                                                                                                                                                         | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Original implementation date | Revised implementation date | Number of Revisions | Actual Implementation Date | Date Final approved | TeamMate state    | TeamMate system update                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----|---------------------------------|----------------------------------------------------------------------|------|-----------------|----------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|---------------------|----------------------------|---------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 643 | Internal Audit                  | Capital Funded Systems                                               | 2022 | Substantial     | Medium   | Matter Arising 1: Consistency of bid submissions (Operation)        | All divisions and core programmes should comply with the requirements as sent out by the Capital Investment Group in the application of the prioritisation criteria as issued prior to the yearly planning process. Where these are not individually ranked this should be passed back to the division for correction. | In developing the capital programme for 2022/23 and beyond the CIG required all divisions and core programmes to rank all schemes. Where this was not undertaken, draft programmes were returned to the relevant division/core programme and revised, ranked programmes were subsequently agreed.                                                                                                                                                                              | 16/05/2022                   |                             |                     | 16/05/2022                 |                     | Closed - Verified |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 221 | Internal Audit                  | Follow up – Audit Wales: Effectiveness of Counter Fraud Arrangements | 2022 | Reasonable      | Low      | Matter Arising 1: Recommendation 2 Resources and Skills (Operation) | The Executive Director of Finance reviews succession planning and service continuity arrangements in line with the Audit Wales report, factoring in other NHS Wales comparators.                                                                                                                                       | The Executive Director of Finance and the Finance Director: Operational Finance have reviewed the structure of the department with the Head of NHS Counter Fraud Wales including benchmarking both the amount of resource and the structure with other Health Boards across Wales. This process will continue to be monitored with the Head of NHS Counter Fraud Wales and all options will be considered for the most appropriate structure and resourcing of the department. | 07/12/2022                   |                             | 0                   | 07/12/2022                 | 22/08/2023          | Implemented       | The Executive Director of Finance and the Finance Director: Operational Finance have reviewed the structure of the department with the Head of NHS Counter Fraud Wales including benchmarking both the amount of resource and the structure with other Health Boards across Wales. This process will continue to be monitored with the Head of NHS Counter Fraud Wales and all options will be considered for the most appropriate structure and resourcing of the department. |

TEAMMATE UPDATE - 2022-2023 RECOMMENDATIONS

APPENDIX 7 - INTERNAL AUDIT - OTHER

Sorted by category

| ID  | Internal Audit/<br>Audit Office | Report Title                         | Year | Assurance Level | Priority | Recommendation Title                                               | Recommendation                                                                                                                                                                                                                                                                                                                                                                                    | Management Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Original<br>implementat<br>ion date | Revised<br>implementati<br>on date | Number of<br>Revisions | Actual<br>Implementation<br>Date | Date Final<br>approved | TeamMate state                      | TeamMate system<br>update                                                                                                                                                                                                                                                                                                                                                               | Audit Category | Audit Comment |
|-----|---------------------------------|--------------------------------------|------|-----------------|----------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------|------------------------|----------------------------------|------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------|
| 115 | Internal Audit                  | Standards of Business Conduct - 2022 | 2022 | Limited         | Medium   | Matter Arising 1: Standards of Business Conduct Policy (Operation) | 1.1: The Standards of Business Conduct policy is reviewed and updated where required, including further information:<br>• Those roles below band 8c that require a declaration of interest<br>• Responsibilities of Governance Leads to ensure compliance within their areas<br>Medium Standards of Business Conduct Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 12 | 1.1: Agreed, the policy has been updated with a view to incorporating best practice identified from the All-Wales Standards of business conduct Policy as well as the requirement for all staff to submit a declaration of interest annually.                                                                                                                                                                                                                                                   | 31/05/2022                          | 31/01/2024                         | 1                      | 12/10/2022                       | 09/02/2024             | Implemented - Final Client Approved | SoBC policy reviewed and approved                                                                                                                                                                                                                                                                                                                                                       | Close          | Superseded    |
| 521 | Internal Audit                  | Delivery of Health Board Savings     | 2023 | No assurance    | High     | Matter Arising 1: Board reporting (Design)                         | 1.1a The finance monthly Board report details the full recurring savings requirement with the IMTP ensuring it details the complete recurring savings in its savings plan, inclusive of all unachieved recurring savings carried over.                                                                                                                                                            | 1.1a: All monthly reporting of the overall finance position and of savings delivery will be against the savings target in the agreed financial plan and associated IMTP. The savings target for the year within the financial plan will take into account unachieved savings from the previous year and the requirement for savings in the plan year, but also the deliverability of savings.                                                                                                   | 31/03/2024                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | All monthly reporting of the overall finance position and of savings delivery will be against the savings target in the agreed financial plan and associated IMTP. The savings target for the year within the financial plan will take into account unachieved savings from the previous year and the requirement for savings in the plan year, but also the deliverability of savings. | Close          | Superseded    |
| 552 | Internal Audit                  | Charitable Funds                     | 2022 | Limited         | Medium   | Matter Arising 5: Fundraising (Design)                             | 5.1: A regular review and analysis of fundraising should be undertaken by the team, with results informing fundraising planning.                                                                                                                                                                                                                                                                  | 5.1: New dedicated data management resource to be in place by end of March 2023 with new reporting for CFC in place by September 2023 to ensure consistent regular review and analysis of fundraising should be undertaken by the team                                                                                                                                                                                                                                                          | 30/09/2023                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | New dedicated data management resource to be in place by end of March 2023 with new reporting for CFC in place by September 2023 to ensure consistent regular review and analysis of fundraising should be undertaken by the team.                                                                                                                                                      | Close          | Superseded    |
| 553 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | Medium   | Matter Arising 1: Business Continuity Working Group (Operation)    | 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                                                                                                                                                                                                   | 1.1a: 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.                                                                                                                                                                                                           | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | All actions completed. see status update                                                                                                                                                                                                                                                                                                                                                | Exec to review |               |
| 554 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | Medium   | Matter Arising 1: Business Continuity Working Group (Operation)    | 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.                                                                                                                                                                                                                                               | 1.1b: 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.                                                                                                                                                                                                                                                                                                                  | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | All actions completed. see status update                                                                                                                                                                                                                                                                                                                                                | Exec to review |               |
| 555 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | Medium   | Matter Arising 1: Business Continuity Working Group (Operation)    | 1.1c: The quorum must be clearer as only one meeting in the last two years was quorate.                                                                                                                                                                                                                                                                                                           | 1.1c: The Terms of reference will be updated to include the revised number of members required for the meetings to be quorate                                                                                                                                                                                                                                                                                                                                                                   | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | All actions completed. see status update                                                                                                                                                                                                                                                                                                                                                | Exec to review |               |
| 556 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | Medium   | Matter Arising 1: Business Continuity Working Group (Operation)    | 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.                                                                                                                                                                                                                                         | 1.1d: The training provision for the BC leads will be reviewed and scheduled to take place from the end of June                                                                                                                                                                                                                                                                                                                                                                                 | 13/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | All actions completed. see status update                                                                                                                                                                                                                                                                                                                                                | Exec to review |               |
| 557 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | High     | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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.                                                                         | 2.1a: 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 | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | Completed - See status updated                                                                                                                                                                                                                                                                                                                                                          | Exec to review |               |
| 558 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | High     | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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.                                                                                                                                                                                                              | 2.1b: Localities need to be advised to report all tested BC plans to the EPRR Team to include lessons identified and action plans                                                                                                                                                                                                                                                                                                                                                               | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | Completed - See status updated                                                                                                                                                                                                                                                                                                                                                          | Exec to review |               |
| 559 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | High     | Matter Arising 2: Incomplete Business Continuity Plans (Operation) | 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).                                                                                                                                                                                                                                 | 2.1c: The Business Continuity Update and Monitoring Reports will include the testing of plans included within the KPIs                                                                                                                                                                                                                                                                                                                                                                          | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | Completed - See status updated                                                                                                                                                                                                                                                                                                                                                          | Exec to review |               |
| 560 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | High     | Matter Arising 3: Escalation of non-completion of BCPs (Operation) | 3.1a: The new Civil Contingencies Assurance Group (CCAG) is formally established and Terms of Reference reflect direct reporting groups.                                                                                                                                                                                                                                                          | 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                                                                                                                                                                                                                                                                                                                                  | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | Completed - see status update                                                                                                                                                                                                                                                                                                                                                           | Exec to review |               |
| 561 | Internal Audit                  | Business Continuity Plans            | 2022 | Limited         | High     | Matter Arising 3: Escalation of non-completion of BCPs (Operation) | 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.                                                                                                                                                                                      | 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                                                                                                                                                                                                                                                        | 30/06/2022                          |                                    |                        |                                  |                        | Implemented - Final Client Approved | Completed - see status update                                                                                                                                                                                                                                                                                                                                                           | Exec to review |               |

|     |                |                |      |         |      |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |            |  |  |  |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                                             |
|-----|----------------|----------------|------|---------|------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|--|--|--|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------------------------------------|
| 562 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.1a: 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.                                                                                                  | 2.1a: 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] | N/A        |  |  |  |  | Implemented - Final Client Approved | Process has been implemented and will be reviewed and monitored to ensure meeting objectives each quarter, when reports being written.                                                                                                                                                                                                                                                                                                                         | Close | Superseded - Clinical audit in plan 2024/25 |
| 563 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.1b: 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.                                                                                                  | 2.1b: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | n/a        |  |  |  |  | Implemented - Final Client Approved | Process has been implemented and will be reviewed and monitored to ensure meeting objectives each quarter, when reports being written.                                                                                                                                                                                                                                                                                                                         | Close | Superseded - Clinical audit in plan 2024/25 |
| 565 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 2 – Annual Clinical Audit Plan (Operation)                                   | 2.2b: Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.                                                                                                                                                                                                                                     | 2.2b: Determine feasibility of augmenting the current document management system (local spreadsheet) as interim measure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30/04/2022 |  |  |  |  | Implemented - Final Client Approved | Process has been implemented and will be reviewed and monitored to ensure meeting objectives each quarter, when reports being written.                                                                                                                                                                                                                                                                                                                         | Close | Superseded - Clinical audit in plan 2024/25 |
| 566 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 3.1: Regular quarterly reports are to be presented to the Quality, Safety and Experience Committee, highlighting progress against the plan.                                                                                                                                                                                                                           | 3.1: 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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/05/2022 |  |  |  |  | Implemented - Final Client Approved | The Clinical Audit plan was submitted to QSE for review and approval on 7th March - this has already been shared at the main Clinical Effectiveness Group on 14th February                                                                                                                                                                                                                                                                                     | Close | Superseded - Clinical audit in plan 2024/25 |
| 567 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 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 | 3.2: 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/04/2022 |  |  |  |  | Implemented - Final Client Approved | The Clinical Audit plan was submitted to QSE for review and approval on 7th March - this has already been shared at the main Clinical Effectiveness Group on 14th February                                                                                                                                                                                                                                                                                     | Close | Superseded - Clinical audit in plan 2024/25 |
| 568 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 3 - Progress reporting (Operation)                                           | 3.3: The overarching Clinical Effectiveness Group should receive regular reports from local Clinical Effectiveness Groups as per the Cycle of Business                                                                                                                                                                                                                | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/05/2022 |  |  |  |  | Implemented - Final Client Approved | The Clinical Audit plan was submitted to QSE for review and approval on 7th March - this has already been shared at the main Clinical Effectiveness Group on 14th February                                                                                                                                                                                                                                                                                     | Close | Superseded - Clinical audit in plan 2024/25 |
| 569 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 4.1a: 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                              | 4.1a: 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31/10/2022 |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |
| 570 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 4.1b: 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                              | 4.1b: Ensure that health check meetings are continued, to secure understanding and engagement / accountability of triumvirates, whilst other changes are in place to ensure consistency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31/05/2022 |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |

|     |                |                |      |         |      |                                                                                             |                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |  |  |  |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                                             |
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| 571 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                      | 4.2: 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 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.                                                                           | 30/09/2022                                                                     |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |
| 572 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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. | 4.3a: 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.                                                                                                                                          | 30/09/2022                                                                     |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |
| 573 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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. | 4.3b: 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 |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |
| 574 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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. | 4.3c: Secure capacity identified within business case (delivering a hub and spoke model to increase capacity within central team aligned to locality.                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/05/2022                                                                     |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to reviewthe process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year. | Close | Superseded - Clinical audit in plan 2024/25 |



|     |                |                |      |         |      |                                                                                             |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                         |            |  |  |  |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |       |                                             |
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| 575 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                               | 4.3d: 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.                                                                                                              | 31/05/2022 |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to review the process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year.                            | Close | Superseded - Clinical audit in 2024/25      |
| 576 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation) | 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.                                                                               | 4.3d: Ensure continuation of current health check meetings to develop and maintain division visibility of audit activity and risks, and to promote engagement and accountability.                                                                                                                                                                       | 31/05/2022 |  |  |  |  | Implemented - Final Client Approved | The proforma for Part A and B which were a WG process ended in February 2022 - and it was down to each health board to monitor this themselves. This gave us the opportunity to review the process and we developed a new form that took into account all actions we wanted to be aware of from the audit cycle process. This was piloted in November 2023 and we will be updating on success and improvements made in the Annual Audit Report later this year.                            | Close | Superseded - Clinical audit in plan 2024/25 |
| 577 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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 | 5.1a: 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 | 30/06/2022 |  |  |  |  | Implemented - Final Client Approved | The self registration process for Tier 3 Audits was introduced in August 2021, each year the process has been reviewed to improve areas that needed to be clearly and mandatory fields developed to get more put in to be clearer with where audit is shared, what has been learnt, what improvements will be made. Currently the data analysis is reviewing further areas to make more improvement. The system is implemented, just we will continue to monitor to improve where possible | Close | Superseded - Clinical audit in plan 2024/25 |
| 578 | Internal Audit | Clinical Audit | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation)                                      | 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.                                  | 5.2: 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                                                                                                                                   | 30/04/2022 |  |  |  |  | Implemented - Final Client Approved | The self registration process for Tier 3 Audits was introduced in August 2021, each year the process has been reviewed to improve areas that needed to be clearly and mandatory fields developed to get more put in to be clearer with where audit is shared, what has been learnt, what improvements will be made. Currently the data analysis is reviewing further areas to make more improvement. The system is implemented, just we will continue to monitor to improve where possible | Close | Superseded - Clinical audit in plan 2024/25 |

|     |                |                                            |      |         |      |                                                        |                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |  |  |  |  |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                             |
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| 579 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation) | 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. | 5.3a: 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                                                                                                                                                                                                                | 31/12/2022 |  |  |  |  |  | Implemented - Final Client Approved | The self registration process for Tier 3 Audits was introduced in August 2021, each year the process has been reviewed to improve areas that needed to be clearly and mandatory fields developed to get more put in to be clearer with where audit is shared, what has been learnt, what improvements will be made. Currently the data analysis is reviewing further areas to make more improvement. The system is implemented, just we will continue to monitor to improve where possible | Close          | Superseded - Clinical audit in plan 2024/25 |
| 580 | Internal Audit | Clinical Audit                             | 2022 | Limited | High | Matter Arising 5- Tier 3 audits (Design and Operation) | 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. | 5.3b: 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.                                                           | 31/03/2023 |  |  |  |  |  | Implemented - Final Client Approved | The self registration process for Tier 3 Audits was introduced in August 2021, each year the process has been reviewed to improve areas that needed to be clearly and mandatory fields developed to get more put in to be clearer with where audit is shared, what has been learnt, what improvements will be made. Currently the data analysis is reviewing further areas to make more improvement. The system is implemented, just we will continue to monitor to improve where possible | Close          | Superseded - Clinical audit in plan 2024/25 |
| 581 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 1: Governance arrangements (Operation)  | 1.1a: Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                                                                                                 | 1.1a (i): Planning has been underway to put a structure in place for West IHC to create 7 Operational Delivery Groups, to mirror what was understood to be the Health Board approach. This work has been paused pending further clarity and an away day to be organised by the Deputy Chief Executive. It is envisaged that the new governance arrangements will be in place to fully commence from the beginning of Q4, 22-23.                                                  | 31/12/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update & further comments submitted. Neil Rogers, Ops Director IHC West                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 582 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 1: Governance arrangements (Operation)  | 1.1a: Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                                                                                                 | 1.1a (ii): Pending the revised governance arrangements for West IHC being approved, pre-existing meetings at Ysbyty Gwynedd will be reconvened, including those that were temporarily stood down, to maintain visibility for the IHC Leadership Team across all areas of the business. This will include a review of their purpose /ToR, and whether they should continue as an Acute only meeting, or be retired and merge in to the appropriate IHC Operational Delivery Group | 31/10/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update & further comments submitted. Neil Rogers, Ops Director IHC West                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 583 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                  | 2.1a: Management to identify and progress savings schemes as a matter of urgency.                                                                                                                                                                                                                                                                    | 2.1a(i): Savings Forum to be established across the newly formed West IHC to include a cross section of operational and clinical teams to establish further proposals for savings schemes to be worked up                                                                                                                                                                                                                                                                        | 30/11/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 584 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                  | 2.1a: Management to identify and progress savings schemes as a matter of urgency.                                                                                                                                                                                                                                                                    | 2.1a(ii): West IHC Senior Team to focus on shorter term rectification / mitigations to manage the financial gap as a result of the incomplete delivery of savings, and identify any further potential transformational schemes and savings through the synergies of coming together as an integrated service.                                                                                                                                                                    | 30/11/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 585 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                  | 2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.                                                                                                                                                                                                                                     | 2.1b(i): Pre-existing Finance & Performance meetings (Area and Ysbyty Gwynedd) to be re-established to maintain overview and scrutiny of the position for Q3 22/23.                                                                                                                                                                                                                                                                                                              | 31/10/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 586 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                  | 2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.                                                                                                                                                                                                                                     | 2.1b(ii): In Line with new Operating Model, IHC F&P Operational Delivery Group to be established when corporate position on desired structure is clarified.                                                                                                                                                                                                                                                                                                                      | 31/01/2023 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                             |
| 587 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation) | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                | 4.1a(i): The new IHC leadership team is concerned about the volume of overdue complaints and the length of time that some complainants are awaiting a response, and considerable effort has already gone in to reducing the backlog, which is much improved as at early October 2022.                                                                                                                                                                                            | 30/11/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update 27th January. Elements within the IHC's direct control have been completed. The Governance Team OCP is awaited which may assist with addressing equity of provision in to the West and enable any vacancies to be filled.                                                                                                                                                                                                                                                | Exec to review |                                             |
| 588 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation) | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                | 4.1a(ii): System of allocating an Investigating Officer for complaints and incidents to be reviewed, to ensure that staff have appropriate training and support, and allocated time to discharge these responsibilities                                                                                                                                                                                                                                                          | 30/11/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update 27th January. Elements within the IHC's direct control have been completed. The Governance Team OCP is awaited which may assist with addressing equity of provision in to the West and enable any vacancies to be filled.                                                                                                                                                                                                                                                | Exec to review |                                             |
| 589 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG) | 2022 | Limited | High | Matter Arising 4: Complaints and incidents (Operation) | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                                                                                                | 4.1a(iii): Oversight of complaints and incidents performance to be formalised via Directorate Accountability meetings on the Ysbyty Gwynedd site                                                                                                                                                                                                                                                                                                                                 | 31/10/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update 27th January. Elements within the IHC's direct control have been completed. The Governance Team OCP is awaited which may assist with addressing equity of provision in to the West and enable any vacancies to be filled.                                                                                                                                                                                                                                                | Exec to review |                                             |

|     |                |                                                       |      |            |      |                                                                                           |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            |  |  |  |  |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                |  |
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| 590 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High | Matter Arising 4: Complaints and incidents (Operation)                                    | 4.1a: Management to review and action overdue incidents and complaints as a priority.                                                                                                                                                                                  | 4.1a(iv): Level of manpower that is provided by the Governance team to support the Directorates on the Ysbyty Gwynedd site to be reviewed and benchmarked against the other sites, together with investigation of the analytical tools available to identify recurring themes / common cause in incidents and complaints                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 31/01/2023 |  |  |  |  |  | Implemented - Final Client Approved | See status update 27th January. Elements within the IHC's direct control have been completed. The Governance Team OCP is awaited which may assist with addressing equity of provision in to the West and enable any vacancies to be filled.                                                                                                                                                                                                                                                                                                                                                                                                                             | Exec to review |  |
| 591 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High | Matter Arising 5: Risk Management (Operation)                                             | 5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions / dates are included                                                                                                                                                  | 5.1a: A full review of the Risk Register will be undertaken across the West IHC to resolve the issues identified at Ysbyty Gwynedd, to include appropriate controls and mitigating actions. There has already been progress as reported at the Risk Management Group on 4th October, with 93% of risks "in date"                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30/11/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Exec to review |  |
| 592 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High | Matter Arising 5: Risk Management (Operation)                                             | 5.1b Management to review consistency of reporting in accordance with the revised governance structure.                                                                                                                                                                | 5.1b: A Risk Operational Delivery Group will be established as part of the revised governance structure with appropriate senior oversight and service representation to ensure that there is consistency of reporting across the West IHC, that risks are appropriately scrutinised and scored and visible on the live register, and appropriate escalation to Tier 1 is followed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/01/2023 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Exec to review |  |
| 593 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High | Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design) | 6.1a(i) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.                                    | 6.1a(i): A cycle of business will be established to ensure that the West IHC maintains oversight that audits are being undertaken across all areas and that the results are being reviewed in the appropriate forum and that any follow up action required is tracked. The Quality Operational Delivery Group, in the revised governance structure, will ensure wider visibility and learning from audit activities across the IHC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/01/2023 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Exec to review |  |
| 594 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High | Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design) | 6.1a(ii) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.                                   | 6.1a(ii): Directorate Accountability meetings at Ysbyty Gwynedd will be relaunched as part of the revised governance structure, and will provide the ability to scrutinise audit activities and follow through of actions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31/10/2022 |  |  |  |  |  | Implemented - Final Client Approved | See status update.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Exec to review |  |
| 595 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital | 2022 | Limited    | High | Matter Arising 1: Governance arrangements (Operation)                                     | 1.1a Governance arrangements are reviewed to ensure compliance with the Integrated Healthcare Community operating model with all Terms of Reference subject to review and approval.                                                                                    | 1.1a Plans to align the governance structure of the IHC with the corporate structure are being finalised with the Associate Director of Governance. Expected timescale to be agreed is 3-4 weeks. • Health and Safety ToR – Signed off 21.10.22 • Risk Management ToR - Signed off 17.11.22 • Finance and Performance ToR – Signed off 16.11.22 • Quality Delivery Group ToR – Signed off 25.10.22 • Senior Leadership ToR- Draft ToR awaiting structure finalisation • Management Group Meeting ToR - Draft ToR awaiting structure finalisation • New WMH Health and Safety and Risk Management ToR 31 January 2023 EIHC Director of Operations Management additional comments: The Acute Site has changed the original TOR to feed into the EIHC Health and Safety meeting and the EIHC Risk Meeting. These meeting report into F&P, Quality for information and or action and to the Executive Risk Management Group and the Executive SOSH Group. The Management Meeting is a work meeting that reports into the F&P meeting, this meeting is used to discuss and agree short term actions. Minutes will report into F&P SLT – Senior Leadership Team A new SLT is being developed as part of the new EIHC governance arrangements, this will sit above the 3 Operational Delivery Groups; (To note when the new governance arrangements have been confirmed by the Executive Management Senior Team, this EIHC Governance arrangements will change to match, this is a draft working arraignment pending any Executive Changes. ☐ Quality ☐ Finance and Performance ☐ Transformation | 31/01/2023 |  |  |  |  |  | Implemented - Final Client Approved | We have the relevant structures and governance in place aligned to the health board •EIHC Service Transformation Group •EIHC Service Quality Group (This does include the H&S as expected) •EIHC Service F&P •EIHC Service People and Culture TOR are aligned to standardised TOR. Normal governance arrangements sit under this                                                                                                                                                                                                                                                                                                                                        | Exec to review |  |
| 596 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital | 2022 | Limited    | High | Matter Arising 4: Complaints (Operation)                                                  | 4.1a Management to review and action overdue complaints as a priority.                                                                                                                                                                                                 | 4.1a: • Trajectory for compliance completed, for weekly monitoring (Complete) • AMMP concerns to be added to weekly concern meeting for tracking • Ombudsman cases to be added to weekly concerns meeting for tracking • Consider expanding weekly meeting to include all IHC services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |  |  |  |  |  | Implemented - Final Client Approved | Control process in place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Exec to review |  |
| 597 | Internal Audit | Impact Assessments                                    | 2022 | Reasonable | High | Matter Arising 2 – Impact Assessments (Operation)                                         | 2.1a: Responsible officers to ensure all Impact Assessments are completed in compliance with Health Board policy, procedure, and legislative requirements. 2.1b Strengthen the scrutiny of Impact Assessment at Executive Delivery Group prior to Board and Committee. | 2.1a/b: The Lead Executive Director Chairs for each Executive Delivery Group will ensure Terms of Reference and monitoring processes incorporate appropriate narrative to include the identification and scrutiny of impact assessments. Once complete/implemented, reference can then be made to the Impact Assessment Screening Tool (IAST). This should support the EDGs in identifying where a particular impact assessment(s) or specialist consultation is required. It will also support informed decision making and provide assurance to decision makers at committee/board that papers have been subject to sufficient Executive scrutiny                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/10/2022 |  |  |  |  |  | Implemented - Final Client Approved | • The IAST received final sign off from the Executive Team (25/01/23) and the Health Board Leadership Team (01/02/23) and is now available via the Policies & Procedures page on BetsiNet. Additional targeted comms have been distributed via the Corporate Bulletin, including the offer of training / awareness sessions via OBS attendance at departmental governance meetings. • Confirmation received from the Associate Director of Governance that the EDG ToRs have appropriate narrative regarding impact assessments • Policy on Policies updated to include reference to IAST (draft, pending confirmation of governance structure and then final approval) | Exec to review |  |

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| 598 | Internal Audit | Impact Assessments    | 2022 | Reasonable | High   | Matter Arising 2 – Impact Assessments (Operation)                                                                            | 2.1c: Policies, procedures, templates and guidance similar to WP7 and WP68 to be established for other Impact Assessments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2.1c: This will be met via the implementation of the Impact Assessment Screening Tool (IAST) which will signpost authors to instances whereby a full impact assessment is required (and the corresponding document/procedure) or to the relevant service/departmental lead. To support the development of the IAST and the review of each impact assessment, the review will: - Scope the range of statutory, mandatory and other impact assessment requirements at both a strategy and policy level - Undertake a gap analysis to identify where policies, procedures, templates and guidance similar to WP7 and WP68 are required for other impact assessments and identify leads to take forward - Develop policies, procedures, templates and guidance for all impact assessments - Align to the IAST - Implement the IAST | 31/10/2022 |  |  |  |  | Implemented - Final Client Approved | <ul style="list-style-type: none"> <li>The IAST received final sign off from the Executive Team (25/01/23) and the Health Board Leadership Team (01/02/23) and is now available via the Policies &amp; Procedures page on BetsiNet. Additional targeted comms have been distributed via the Corporate Bulletin, including the offer of training / awareness sessions via OBS attendance at departmental governance meetings.</li> <li>Confirmation received from the Associate Director of Governance that the EDG ToRs have appropriate narrative regarding impact assessments</li> <li>Policy on Policies updated to include reference to IAST (draft, pending confirmation of governance structure and then final approval)</li> </ul> | Exec to review |                                       |
| 599 | Internal Audit | Impact Assessments    | 2022 | Reasonable | High   | Matter Arising 2 – Impact Assessments (Operation)                                                                            | 2.1d: The conditions or criteria triggering the requirement to undertake a Full Equality Impact Assessment should be clearly noted in the relevant Impact Assessment documents (Part A or Part B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2.1d: The Equality Impact Assessment (EqIA) Tool Part B, question 3 has been reviewed and strengthened to further clarify the criteria triggering the requirement for full EqIA. Links to the Equality Team have also been included and authors signposted to contact the team if they require further support to decide if a full EqIA is required. • The revised EqIA Tool has been included on the agenda for the Equality and Human Rights Strategic Forum meeting 21/06/22 for approval. When approved, this version will be uploaded onto BetsiNet                                                                                                                                                                                                                                                                       | 31/10/2022 |  |  |  |  | Implemented - Final Client Approved | <ul style="list-style-type: none"> <li>The IAST received final sign off from the Executive Team (25/01/23) and the Health Board Leadership Team (01/02/23) and is now available via the Policies &amp; Procedures page on BetsiNet. Additional targeted comms have been distributed via the Corporate Bulletin, including the offer of training / awareness sessions via OBS attendance at departmental governance meetings.</li> <li>Confirmation received from the Associate Director of Governance that the EDG ToRs have appropriate narrative regarding impact assessments</li> <li>Policy on Policies updated to include reference to IAST (draft, pending confirmation of governance structure and then final approval)</li> </ul> | Exec to review |                                       |
| 606 | Internal Audit | Targeted Intervention | 2022 | Limited    | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.1: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.1: New SRO for Engagement Domain has been identified – Director of Partnerships, Engagement and Communication                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | N/A        |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Board regularly along with report each meeting. SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Close          | Superseded by special measures review |
| 607 | Internal Audit | Targeted Intervention | 2022 | Limited    | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.2: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.2: Terms of Reference to be reviewed and presented to TIIF Steering Group                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/03/2022 |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Board regularly along with report each meeting. SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Close          | Superseded by special measures review |

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| 608 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.3: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.3: Reporting arrangements to be incorporated within the ToR Review                          | 31/03/2022 |  |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Baord regularly along with report each meeting, SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                         | Close | Superseded by special measures review |
| 609 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.4: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.4: Minutes of reporting groups will be taken and a CAR provided to the TIF Steering Group   | 01/01/2022 |  |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Baord regularly along with report each meeting, SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                         | Close | Superseded by special measures review |
| 610 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.5: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.5: A position on the mapping of the TI actions in line with the Annual Plan will be agreed. | 30/04/2022 |  |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Baord regularly along with report each meeting, SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                         | Close | Superseded by special measures review |
| 611 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.1 - Targeted Intervention Improvement Framework Steering Group and Sub-Groups (Operating effectiveness) | 1.6: The Health Board, through the Steering Group Chair: • Identifies a new SRO for the Engagement Domain. • Ensures the Terms of Reference for the Steering Group and all Groups reporting to it are reviewed and complied with/established where none exist presently. • Ensures all Terms of Reference accurately reflect the reporting arrangements and operation of each meeting e.g., Chair/Vice Chair detailed/All groups reporting to the meeting are detailed. • Ensures those reporting to the Steering Group and below have complete Minutes to ensure respective Terms of Reference are met (e.g., Quorum). • Clarity is provided to the Health Board regarding the mapping of the TI actions in line with the Annual Plan. • All Evidence Group meetings receive the evidence supporting new attributes and not summary sheets from an operational Check & Challenge Group. | 1.6: Full evidence will remain available to the Evidence and Outcomes Groups                  | 01/01/2022 |  |  |  |  |  | Implemented - Final Client Approved | ToR amended, CAR now going to Baord regularly along with report each meeting, SRO for engagement appointed, evidenc group met with fiull access to all papers                                                                                                                         | Close | Superseded by special measures review |
| 612 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.2 – Welsh Government Framework requirements (Operating effectiveness)                                   | 2: The Health Board ensure the Framework for the additional financial investment is completed and shared with the Board and Welsh Government.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2: Framework to be shared with Welsh Government.                                              | 31/01/2022 |  |  |  |  |  | Implemented - Final Client Approved | Welsh Government are kept informed on a regular basis within Touchpoint meetings. More recently a detailed report on utilisation of expenditure in relation to performance and transformation funding was provided at the meeting on 1st February with the WG Financial Delivery Unit | Close | Superseded by special measures review |
| 613 | Internal Audit | Targeted Intervention | 2022 | Limited | Medium | Matter Arising - ISS.3 – Targeted Intervention supporting evidence (Operating effectiveness)                                 | 3: The Chair of the Evidence Group requests further evidence from the SRO for Mental Health & CAMHS concerning Attribute M14.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3: Completed and will be presented to the next Evidence Group.                                | 31/03/2022 |  |  |  |  |  | Implemented - Final Client Approved | action achieved                                                                                                                                                                                                                                                                       | Close | Superseded by special measures review |

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| 638 | Internal Audit | Learning Lessons                                                                 | 2022 | Reasonable | High   | Matter Arising 1 – Learning across the Health Board (Design) | 1.1a: Following the above changes, the process that divisions / areas are required to follow, and documentation they need to complete, should be updated in the Putting Things Right policy and / or the Concerns Procedure. 1.1b The Health Board should consider the development of a 'Learning Lessons' framework/policy, which describes the process and procedures to ensure that lessons learned from all types of events are captured in a consistent approach, and there are mechanisms in place to disseminate the learning across the Health Board. The framework should aim to provide staff access to learning from both incidents and complaints.                                                                    | The Health Board has work already underway and will develop a Learning from Events Framework setting out how learning will be captured, cascaded and evidenced. This will be detailed in the Incident Policy and Procedure and Complaints Policy and Procedure. The framework will include:<br>• A standardised monthly learning bulletin from the Incident Learning Panel<br>• A standardised learning template ("learning on a page") that will be completed as part of every serious incident review and serious complaints review<br>• Development of a learning library as part of the new Intranet<br>• A bi-monthly Health Board wide "Learning Grand Round" to alternate with a bi monthly Quality Grand Round – the sessions will be online and captured and placed as part of the learning library<br>• A requirement as part of the serious incident and complaint review process to hold "learning events" for each investigation using a methodology like the Oxford Model<br>– the evidence of which will be captured<br>• A refresh of the Safety Alerts Policy and Procedure and standardised internal safety alert template and process<br>• The development of a Patient Safety Programme driving forward transformational change across the Health Board in response to key areas of harm or opportunity identified from the strengthened learning | 30/06/2022 | 31/03/2023 | 2 | 31/01/2023 |  | Implemented - Final Client Approved | A number of improvements have been made. These are: Re-alignment of the quality function including strengthening learning in the Quality Directorate role (see attached). - New Organisational Learning Forum. - New Weekly Harm Free Care Learning Forum. - Updated format Patient Safety Report (see attached). - Updated format Patient and Carer Experience Report (see attached). - New NRI Report to QSE (see attached). - New Quality Learning Bulletin. - Commission human factors investigation training (see attached).                                                                                                                                                                                                                                                                                                                                                                                                                     | Exec to review |                                                                |
| 639 | Internal Audit | Learning Lessons                                                                 | 2022 | Reasonable | Medium | Matter Arising 2 – Reporting (Design)                        | Information on examples of specific lessons learned and how these have been implemented / evidenced as having made a difference should be reported to the Quality, Safety and Experience Committee to provide assurance that lessons learned have been implemented and have made a difference                                                                                                                                                                                                                                                                                                                                                                                                                                     | The Patient Safety Report is evolving in discussion with the Executive Lead and QSE Committee Chair. Assurances around lessons learned will be embedded as part of this report. This will include providing examples of lessons learned in the report as recommended. The development of a new Patient Safety Programme, informed by risk and reported to the Committee, will also strengthen visibility and assurance of improvement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01/03/2022 | 03/05/2022 | 1 | 03/05/2022 |  | Implemented - Final Client Approved | See action update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 640 | Internal Audit | Network and Information Systems Regulations 2018 (NIS Regulations)               | 2022 | Reasonable | Medium | Funding clarity                                              | Indicative costs should be provided for all identified actions, and the full picture provided to PPPH to ensure awareness of the risks and cost implications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Review resources within the Cyber Security and Compliance Team in relation to delivery of CAF actions and BAU. Develop business case to address existing, significant resource limitations which at present is not conducive to sustainably meeting ever increasingly regulatory, accountability and responsibility for compliance. Develop business cases to maintain and improve existing technologies required to sustain the Health Board's current security posture and deliver against CAF actions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31/01/2023 |            | 0 | 03/02/2023 |  | Implemented - Final Client Approved | Please refer to recent update status. Business Case developed and submitted to Committee and Board. Action completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 641 | Internal Audit | Network and Information Systems Regulations 2018 (NIS Regulations)               | 2022 | Reasonable | Low    | Matter Arising 1: System Owner Involvement (Operation)       | 1.1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | • Develop and circulate a NIS Briefing to System Owners ahead of 2022 CAF process<br>• Develop NIS Intranet page highlighting System Owner responsibilities<br>• Share 2022 CAF submission with System Owners and provide them with a window to review, query and comments<br>• ICT will be convening and taking ownership of a newly re-formed Systems Owners group due to the importance to ICT of BCM and NIS-R matters. This will be reflected in the new terms of reference, to be agreed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/01/2023 | 25/12/2023 | 1 | 20/06/2023 |  | Implemented - Final Client Approved | As noted, WG did not require Health Boards to complete the CAF submission during 2022. As part of the wider review of the Health Boards Asset Register, it has become apparent that System Owners have either moved or left and the role has not been transferred, or the entry is significantly out of date. Therefore in addition to review the setup and constitution of the System Owners Group, a full review of the register is underway. This includes ensuring all systems have a current owner who fully understands their role and responsibility and will include an appendix being added to their Job Description to capture this requirement. It also includes ensuring all contracts are current and in place as well as business continuity plans. A proposal is also being put forward to reduce the volume of silo systems, closing down those no longer in use once clear processes have been put in place to ensure data transfer. | Exec to review | Wouldn't look at this as reasonable report and low priority    |
| 642 | Internal Audit | Network and Information Systems Regulations 2018 (NIS Regulations)               | 2022 | Reasonable | Medium | Matter Arising 2: Assessment Evidence (Operation)            | Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | During future CAF processes, any communications with Cyber Resilience Unit which relate to key decisions or points of clarity will be saved in the NIS SharePoint folder. A summary of decisions and discussion internally in relation to the CAF process is already kept in the form of minutes from our weekly IT Security Catch-up meetings. <i>(This recommendation is included as N/A within the audit report, and a N/A listed as responsible officer.)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31/01/2023 |            | 0 | 25/01/2023 |  | Implemented - Final Client Approved | A SharePoint folder structure has been developed for the Cyber Security and Compliance Team Any communication with CRU which is key to Cyber Security (in terms of points of clarity) will be stored in this location going forward.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 656 | Internal Audit | Cluster working/ Health and Social Care Localities governance and accountability | 2022 | Reasonable | Medium | Matter Arising 1 – Terms of Reference (Operation)            | 1.1: Whilst we recognise the impact that the Covid pandemic has had on the role and contractual requirements of the Clusters, Terms of Reference must be reviewed and agreed to ensure continued relevance. Management to consider opportunity for efficiency gains by standardising Cluster Terms of Reference whilst maintaining provision for local arrangementsWhilst we recognise the impact that the Covid pandemic has had on the role and contractual requirements of the Clusters, Terms of Reference must be reviewed and agreed to ensure continued relevance. Management to consider opportunity for efficiency gains by standardising Cluster Terms of Reference whilst maintaining provision for local arrangements | 1.1: The review of the ToR is already underway and will be included as an item on all upcoming cluster meetings and current ToR has been circulated to all cluster leads for reviewing in preparation for discussion at the cluster meetings. Revised TOR will need to reflect the all Wales implementation of the Accelerated Cluster Development (ACD) programme and any related contractual changes for practices, as well as the implementation of the health board's new operating model. Once the discussion has taken place the reviewed ToR will be circulated with the clusters and cluster teams for agreement and dated – the ToR will be reviewed each year in the 1st cluster meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/06/2022 |            | 0 | 13/06/2022 |  | Implemented - Final Client Approved | Cluster meeting ToRs reviewed and agreed in June 2022. Will be reviewed annually moving forward                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 657 | Internal Audit | Cluster working/ Health and Social Care Localities governance and accountability | 2022 | Reasonable | Low    | Matter Arising 2 – Meeting Actions (Operation)               | 2.1: Progress against agreed actions to be recorded. West Area Cluster Leads Meeting Chair to consider retaining meeting minutes to supplement action log.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2.1: Action log will be added alongside the meeting minutes as per each Area, these actions will be agreed on within the cluster meetings. Good practice will be shared across the primary care contractor professions when establishing the separate collaboratives as a result of the ACD programme. The action log will be reviewed and updated at the beginning of each cluster meeting with the matters arising also recorded in the meeting minutes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 30/09/2022 |            |   | 30/08/2022 |  | Implemented - Final Client Approved | Action Logs are now embedded within the cluster meeting notes and are discussed and agreed in cluster meetings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review | Wouldn't look at this as reasonable report and low priority    |



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| 658 | Internal Audit | Cluster working/ Health and Social Care Localities governance and accountability | 2022 | Reasonable  | Low    | Risk Register                                                                                         | 3.1: We acknowledge the importance of Cluster autonomy, however management to consider standardising the approach to managing and reporting Cluster risks.                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3.1: Risk register will be added alongside the meeting minutes as per each Area these cluster specific risks will be agreed on within the cluster meetings. Good practice will be shared across the primary care contractor professions when establishing the separate collaboratives as a result of the ACD programme. The risks will be reviewed and updated at the beginning of each cluster meeting with the matters arising also recorded in the meeting minutes.                       | 30/09/2022 |            | 0 | 21/09/2022 |  | Implemented - Final Client Approved | Risk registers are now discussed in cluster meetings and are included with the meeting actions logs. Risks are escalated in monthly reports to Area Leaderships teams when required                                                                                                                                                                                                                                                                                                                                                                                                                                 | Exec to review | Wouldn't look at this as reasonable report and low priority    |
| 659 | Internal Audit | Waste Management                                                                 | 2022 | Reasonable  | Medium | Matter Arising 1 – Effective Communication of Waste Management Policy / Training (Design)             | 1: Mandatory training on waste management should be made available to all staff groups across the Health Board, this will ensure effective communication of the waste management policy and other associated documents.                                                                                                                                                                                                                                                                                                                                                                        | 1: Estates and Facilities have contributed to and adopted an All-Wales online mandatory training module for all BCUHB staff covering waste, environment and energy management. The e-module is currently only available to some staff through ESR. In compliance with this recommendation the Director of Estates and Facilities will work with Senior WOD colleagues who have responsibility for mandatory training, to ensure that the e-learning module is available to all staff via ESR | 30/06/2022 |            |   | 04/08/2022 |  | Implemented - Final Client Approved | This outstanding action has now been implemented and the attached report which was approved by the Health Board's Mandatory Training group provides the relevant evidence.                                                                                                                                                                                                                                                                                                                                                                                                                                          | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 660 | Internal Audit | Voluntary Early Release Scheme (VERS) - May 2022                                 | 2022 | Reasonable  | High   | Matter Arising 1 – Section 7: VERS Approval Process (Operating effectiveness)                         | 1.1: Executive Directors ensure all steps detailed by the VER Scheme are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.<br>1.2: The Executive Director of Finance confirms the calculation of all reported costs/recurrent savings and provides assurance to Committee that the establishment and savings for all posts being removed/downgraded/reinvested savings have been actioned. | 1.1: Update reports to be provided to Remuneration and Terms of Service Committee to include confirmation of the final terms agreed within each of the associated Settlement Agreements.                                                                                                                                                                                                                                                                                                     | 31/07/2022 | 01/09/2022 | 2 | 05/09/2022 |  | Implemented - Final Client Approved | RTS report 1.9.22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Close          | Superseded                                                     |
| 661 | Internal Audit | Voluntary Early Release Scheme (VERS) - July 2022                                | 2022 | Reasonable  | Medium | Matter Arising 1 – Section 7: VERS Approval Process (Operating effectiveness)                         | 1.1: The RaTSC Minutes of the 30th March 2022 be updated to record the chronology of decisions taken outside the Committee meeting for accuracy.                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1.1: A post meeting update will be appropriately recorded in the Committee Chairs Assurance report to the Board                                                                                                                                                                                                                                                                                                                                                                              | 31/08/2022 |            |   | 30/09/2022 |  | Implemented - Final Client Approved | RTS post meeting note completed. VERS closure report considered at RTS meeting 1.9.22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 662 | Internal Audit | Voluntary Early Release Scheme (VERS) - July 2022                                | 2022 | Reasonable  | Medium | Matter Arising 2 – Section 9: Settlement Agreement – Return of equipment/information (Control Design) | 2.1: Line Managers (approving officers for VERS applications) for all individuals leaving through VER Scheme provide assurance to the Executive Director of Workforce & OD that all exit procedures have been complied with. In particular, focus on the return of Health Board information, ID badge/keys and notification to Informatics to end-date access to all NHS Wales systems and return of IT equipment/phones etc.                                                                                                                                                                  | 2.1: Line managers required to confirm that all exit procedures complied with for individuals who have left due to VERS                                                                                                                                                                                                                                                                                                                                                                      | 30/09/2022 |            |   | 29/09/2022 |  | Implemented - Final Client Approved | All managers have been contacted to ensure that exit procedures adhered to. This process is built into the revised VERS policy which was approved at RTS Committee 1st September 2022                                                                                                                                                                                                                                                                                                                                                                                                                               | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 663 | Internal Audit | Speak Out Safely                                                                 | 2022 | Reasonable  | Medium | Matter Arising 2: Project plan update (Operation)                                                     | 2.1a: Review plan and ensure all activities have target dates, progress and RAG ratings assigned.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2.1a: The project plan will be updated to include all recommendations set out (project plan has been updated and provided for reference).                                                                                                                                                                                                                                                                                                                                                    | 30/11/2022 |            |   | 12/12/2022 |  | Implemented - Final Client Approved | Project plan updated as per recommendations from Audit Team. Audit team have signed off audit report as final copy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 664 | Internal Audit | Welsh Information Governance Toolkit                                             | 2022 | Substantial | Low    | Matter Arising 1 – Evidence of training (Operation)                                                   | 1: As part of the process for the completion of the 2022/23 toolkit, consideration should be given to ensuring the appropriate detailed evidence is provided in line with the requirements of the IG toolkit.                                                                                                                                                                                                                                                                                                                                                                                  | 1.1: Steps will be taken to address the SIRO Job Description recommendation; The SIRO role is changing from Sue Hill to Dylan Roberts during 2022/23 so we will ensure SIRO is incorporated within the Job Description of the Chief Digital Information Officer with the support of the roles and responsibilities appendix.                                                                                                                                                                 | 31/10/2022 |            | 0 | 01/11/2022 |  | Implemented - Final Client Approved | GDPR Training Compliance included on ATHR Staff Details log identifying when certification completed. Currently 6 out of 14 staff members within the team have completed GDPR Training (level relevant to their role). Out of the remaining 8 staff, 2 have been on long term sickness absence and not yet been able to complete and 6 are new staff within the team who have joined within the last 12 months. GDPR Training has been purchased and scheduled for staff to complete before the end of the 2022/23 financial year as required to spread out training due to volume of activity and staff shortages. | Exec to review | Wouldn't look at this as reasonable report and low priority    |
| 665 | Internal Audit | Welsh Information Governance Toolkit                                             | 2022 | Substantial | Low    | Matter Arising 2 – Improvement Plan (Operation)                                                       | 2: The improvement plan should be updated to include:<br>• A specific action against the improvement for Mental Health Records 5.1.1.3.<br>• Responsible officers / job titles against the 'Responsible person' column.                                                                                                                                                                                                                                                                                                                                                                        | 2.1: High level actions should be mirrored on the IG toolkit priorities improvement plan. Responsible officer to provide full details for submission.                                                                                                                                                                                                                                                                                                                                        | 31/10/2022 |            |   | 10/10/2022 |  | Implemented - Final Client Approved | Action has been implemented, Improvement plan for 2021/22 has been updated with responsible persons and action carried over from 2020/21 submission for 5.1.1.3. See Attached. The IG toolkit subgroup is commencing its first meeting for the 2022/23 submission in November and all priorities identified in the 2021/22 improvement plan will be managed through this group.                                                                                                                                                                                                                                     | Exec to review | Wouldn't look at this as reasonable report and low priority    |

|      |                |                                                                      |      |            |        |                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            |            |   |            |  |                                     |                                                                                                                                                                                                                                                                                                                                                                         |                |                                                                |
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| 666  | Internal Audit | Follow up – Audit Wales: Effectiveness of Counter Fraud Arrangements | 2022 | Reasonable | Medium | Matter Arising 3: Recommendation 3 – Data Analytics (Operation)                  | In furthering the use of data analytics across the Health Board, the Counter Fraud Team develop a list of all data systems cutting across the Health Board and work with Data Owners/Digital, Data and Technology that data is made available when such reviews are instigated. Opportunities to use functionality of MS Excel and Power BI are further considered in the short-term. | A member of the Counter – Fraud Team will be attending a data analytics course in December 2022. Opportunities to undertake further analytics work will be considered once the individual has completed the course. A list of data systems is already available within the Information Governance Team.                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/01/2023 |            | 0 | 14/02/2023 |  | Implemented - Final Client Approved | Implementation Actions updated 14/02/2023                                                                                                                                                                                                                                                                                                                               | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1246 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Low    | Matter Arising 1 - RM01 Policy (Operating effectiveness)                         | 1: Segregate the Strategy from the Policy and follow the Office of the Board's Secretary's Policy on Policies with the strategy being an overarching document on the Risk Management landing page of the Intranet/Internet.                                                                                                                                                           | 1: To remove “Policy” from the document title and relaunch as part of the revised RM01 - Risk Management Strategy on the Policy Database with a link created from the Risk Management landing page, so there is only one source of the truth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/07/2022 | 31/08/2021 | 1 |            |  | Implemented - Final Client Approved | 04/10/2022- Molly Marcu has updated and sent to PH and PR the final Risk Management Strategy.                                                                                                                                                                                                                                                                           | Exec to review | Wouldn't look at this as reasonable report and low priority    |
| 1247 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 2 – Consistency of risks across the Health Board (Control design) | 2: The Risk Management Group should receive full risk registers on a regular basis from different departments / divisions to enable scrutiny. Risk Managers to ensure that departments are scoring risks consistently across the Health Board and review in detail those areas identifying an unusually high or low number of risks                                                   | 2: To incorporate the following actions as part of the 2022/23 Risk Work Plan:<br>1. As part of the Departmental Risk Reports all live Tier 2 and 3 risks to be extracted from Datix and inserted as an excel spreadsheet within the reports.<br>2. Corporate Regional Risk Managers to review current system and establish contact with risk leads for any risks sitting outside of risk rating tiers.<br>3. Corporate Risk Team to meet with services to develop Pan-BCU risks where common themes are identified.<br>4. Corporate Risk Team to review all risks on Datix and where there are inconsistencies in numbers, (whether low or high compared with others), to contact the risk leads to support further register development. | 31/05/2022 | 30/07/2022 | 1 |            |  | Implemented - Final Client Approved | Please see attached work plan as evidence of ongoing tasks added to the annual work programme for the Risk Team                                                                                                                                                                                                                                                         | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1248 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 3 – Departmental risk registers (Operating effectiveness)         | 3: Although Risk Management report solely on the Risk Score (as opposed to Tier) reporting is incomplete and decisions need to be taken to either escalate the risk based on the score or to assess the likelihood to comply with reporting/management Tier. Consideration that field completion is compulsory, where possible and review the list of fields for use and benefits.    | 3.1: Review current Datix system and turn the Manager, Pan BCU risk sections mandatory.<br>3.2: Further review all fields and remove those which are not used or reported on.<br>3.3: Ensure updates above are captured as part of the Once for Wales Risk Module Programme.                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/06/2022 |            |   |            |  | Implemented - Final Client Approved | Evidence can be viewed directly within the Datix system                                                                                                                                                                                                                                                                                                                 | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1249 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 4 - Research and Development and Clinical School (Control design) | 4: Research & Development risk is reviewed and wider consideration on the impact to the Health Board included. The risks associated with the North Wales Medical and Health Sciences School (impacting on the Health Board) be recorded on the Health Board Risk Register                                                                                                             | 4.1: To meet with the Research and Development lead and support updating the current risks.<br>4.2: To meet with the North Wales Medical and Health Sciences School lead to support the identification and recording of the risks.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31/05/2022 | 23/06/2022 | 2 |            |  | Implemented - Final Client Approved | As per previous status update, recommendation is complete.                                                                                                                                                                                                                                                                                                              | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1250 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 5 – Escalation and de-escalation of risks (Control design)        | 5.1: The RM Department consider an addition of 'Approved date by Executive Team' in order to record the time line of the escalation/de-escalation of Risks by the Health Board.                                                                                                                                                                                                       | 5.1: Datix to be updated to capture the additional “Approved date by Executive Team” for all Corporate Risks.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31/05/2022 | 31/08/2022 | 1 |            |  | Implemented - Final Client Approved | see progress update and evidence submited                                                                                                                                                                                                                                                                                                                               | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1252 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 6 – Risk Management Group (Operating effectiveness)               | 6: The Terms of Reference for the Risk Management Group are reviewed to ensure Membership enables meetings to progress and remain quorate.                                                                                                                                                                                                                                            | 6: To review and update the Risk Management Terms of Reference.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 30/06/2022 | 31/01/2025 | 2 |            |  | Implemented - Final Client Approved | The RMG TOR was updated to reflect the CEO as chair and approved at RMG 04th August 2022. The assessment is that this recommendation can be closed however it is anticipated that further potential to governance changes from Audit to QSE may be required, this would be monitored by the corporate risk management team with option for internal audit to follow up. | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1253 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | Medium | Matter Arising 7 - Never Events (Control design)                                 | 7: A revisit of the current risk ID4261 is required to ensure the risk is reflective of all Never Events and is being effectively mitigated/controlled.                                                                                                                                                                                                                               | 7: To meet with the Responsible Officer for Never Events and review the risk.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23/06/2022 | 31/08/2022 | 1 |            |  | Implemented - Final Client Approved | Meeting held, current Tier 2 risk reflective of the BCU wide Never Event process, now working with local leads to identify individual service never events which will be linked into the overarching Tire 2 BCU wide Never Event Risk, see attached emails as evidence.                                                                                                 | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 1254 | Internal Audit | Risk Management - June 2022                                          | 2022 | Reasonable | High   | Matter Arising 8 - Moving from Five to Three Tiers (Operating effectiveness)     | 8: A full review of all risks should be undertaken by operational managers to ensure that all risks are scored correctly and that they have been allocated to the correct Tiers. All reviewed risks should be signed off by the RM department and the risk owner following review.                                                                                                    | 8: To update the Risk Management Work Plan to capture a full review of all risks with each Departmental Risk Lead and ensure alignment with the Risk Management Strategy. To report completion of action as part of the Quarterly Key Performance Indicator Reports.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 31/05/2022 | 23/06/2022 | 1 |            |  | Implemented - Final Client Approved | Please see attached workplan and the template quarterly KPI report to support completion of this action.                                                                                                                                                                                                                                                                | Close          | Superseded                                                     |

|      |                |                                                  |      |             |        |                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                    |            |            |   |            |  |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                 |
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| 1257 | Internal Audit | Welsh Information Governance Toolkit             | 2022 | Substantial | Medium | Matter Arising 1 – Evidence of training (Operation)                           | 1: As part of the process for the completion of the 2022/23 toolkit, consideration should be given to ensuring the appropriate detailed evidence is provided in line with the requirements of the IG toolkit.                                                                                                                                                                                                                                                                                                                                                                                  | 1.2: Caldicott will attend the Advanced Caldicott Guardian Masterclass in October 2022.                                                                                                                                                                                                                                                            | 31/10/2022 |            | 0 | 01/11/2022 |  | Implemented - Final Client Approved | GDPR Training Compliance included on ATHR Staff Details log identifying when certification completed. Currently 6 out of 14 staff members within the team have completed GDPR Training (level relevant to their role). Out of the remaining 8 staff, 2 have been on long term sickness absence and not yet been able to complete and 6 are new staff within the team who have joined within the last 12 months. GDPR Training has been purchased and scheduled for staff to complete before the end of the 2022/23 financial year as required to spread out training due to volume of activity and staff shortages. | Exec to review | Wouldn't look at this as substantial report and medium priority |
| 1258 | Internal Audit | Welsh Information Governance Toolkit             | 2022 | Substantial | Medium | Matter Arising 1 – Evidence of training (Operation)                           | 1: As part of the process for the completion of the 2022/23 toolkit, consideration should be given to ensuring the appropriate detailed evidence is provided in line with the requirements of the IG toolkit.                                                                                                                                                                                                                                                                                                                                                                                  | 1.3: Whilst there was a number of certificates provided for ATHR staff to evidence GDPR Foundation & Practitioner training all staff could not be evidenced. ATHR manager will create a log which evidences the additional training and the certificates in a central location. This will enable training to be tracked and monitored accordingly. | 31/10/2022 |            | 0 | 01/11/2022 |  | Implemented - Final Client Approved | GDPR Training Compliance included on ATHR Staff Details log identifying when certification completed. Currently 6 out of 14 staff members within the team have completed GDPR Training (level relevant to their role). Out of the remaining 8 staff, 2 have been on long term sickness absence and not yet been able to complete and 6 are new staff within the team who have joined within the last 12 months. GDPR Training has been purchased and scheduled for staff to complete before the end of the 2022/23 financial year as required to spread out training due to volume of activity and staff shortages. | Exec to review | Wouldn't look at this as substantial report and medium priority |
| 1259 | Internal Audit | Welsh Information Governance Toolkit             | 2022 | Substantial | Low    | Matter Arising 2 – Improvement Plan (Operation)                               | 2: The improvement plan should be updated to include:<br>• A specific action against the improvement for Mental Health Records 5.1.1.3.<br>• Responsible officers / job titles against the 'Responsible person' column.                                                                                                                                                                                                                                                                                                                                                                        | 2. We will ensure a responsible person for the above actions will be documented rather than a department.                                                                                                                                                                                                                                          | 31/10/2022 |            |   | 10/10/2022 |  | Implemented - Final Client Approved | Action has been implemented, Improvement plan for 2021/22 has been updated with responsible persons and action carried over from 2020/21 submission for 5.1.1.3. See Attached. The IG toolkit sub group is commencing its first meeting for the 2022/23 submission in November and all priorities identified in the 2021/22 improvement plan will be managed through this group.                                                                                                                                                                                                                                    | Exec to review | Wouldn't look at this as substantial report and low objective   |
| 1261 | Internal Audit | Voluntary Early Release Scheme (VERS) - May 2022 | 2022 | Reasonable  | High   | Matter Arising 1 – Section 7: VERS Approval Process (Operating effectiveness) | 1.1: Executive Directors ensure all steps detailed by the VER Scheme are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.<br>1.2: The Executive Director of Finance confirms the calculation of all reported costs/recurrent savings and provides assurance to Committee that the establishment and savings for all posts being removed/downgraded/reinvested savings have been actioned. | 1.2: Updates on actions to taken to mitigate risks identified in terms of transition to new model, loss of organisational systems of control and loss of organisational knowledge to be provided to members of the Committee.                                                                                                                      | 31/07/2022 | 01/09/2022 | 2 | 05/09/2022 |  | Implemented - Final Client Approved | RTS report 1.9.22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Close          | Already closed through follow up                                |
| 1262 | Internal Audit | Voluntary Early Release Scheme (VERS) - May 2022 | 2022 | Reasonable  | High   | Matter Arising 1 – Section 7: VERS Approval Process (Operating effectiveness) | 1.1: Executive Directors ensure all steps detailed by the VER Scheme are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.<br>1.2: The Executive Director of Finance confirms the calculation of all reported costs/recurrent savings and provides assurance to Committee that the establishment and savings for all posts being removed/downgraded/reinvested savings have been actioned. | 1.3: Final VERS closure report to be submitted to the Committee detailing final costs and savings released as a result of VERS applications                                                                                                                                                                                                        | 31/07/2022 | 01/09/2022 | 2 | 05/09/2022 |  | Implemented - Final Client Approved | RTS report 1.9.22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Close          | Already closed through follow up                                |

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| 1263 | Internal Audit | Voluntary Early Release Scheme (VERS) - July 2022     | 2022 | Reasonable | Medium | Matter Arising 1 – Section 7: VERS Approval Process (Operating effectiveness)                         | 1.2: For future VER Scheme rounds, all controls detailed are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1.2: VERS Scheme documentation to be updated to reflect learning identified from this Audit and from the management of the process. This will be submitted to Remuneration and Terms of Service Committee at its next planned meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 30/09/2022 |            |   |            | 30/09/2022 |                                       | Implemented - Final Client Approved                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | RTS post meeting note completed. VERS closure report considered at RTS meeting 1.9.22                                                                                                 | Exec to review                                                 | Wouldn't look at this as reasonable report and medium priority |
| 1264 | Internal Audit | Voluntary Early Release Scheme (VERS) - July 2022     | 2022 | Reasonable | Medium | Matter Arising 2 – Section 9: Settlement Agreement – Return of equipment/information (Control Design) | 2.2: Line Managers (approving officers for VERS applications) for all individuals leaving through VER Scheme provide assurance to the Executive Director of Workforce & OD that all exit procedures have been complied with. In particular, focus on the return of Health Board information, ID badge/keys and notification to Informatics to end-date access to all NHS Wales systems and return of IT equipment/phones etc.                                                                                                                                                                                                                                                                                                                                                                          | 2.2: Line managers advised of requirement to undertake exit procedures as part of leaving procedures for individuals leaving in the future.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/09/2022 |            |   |            | 29/09/2022 |                                       | Implemented - Final Client Approved                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | All managers have been contacted to ensure that exit procedures adhered to. this process is built into the revised VERS policy which was approved at RTS Committee 1st September 2022 | Exec to review                                                 | Wouldn't look at this as reasonable report and medium priority |
| 1265 | Internal Audit | Voluntary Early Release Scheme (VERS) - July 2022     | 2022 | Reasonable | Medium | Matter Arising 2 – Section 9: Settlement Agreement – Return of equipment/information (Control Design) | 2.3: Line Managers (approving officers for VERS applications) for all individuals leaving through VER Scheme provide assurance to the Executive Director of Workforce & OD that all exit procedures have been complied with. In particular, focus on the return of Health Board information, ID badge/keys and notification to Informatics to end-date access to all NHS Wales systems and return of IT equipment/phones etc.                                                                                                                                                                                                                                                                                                                                                                          | 2.3: Amended VERS scheme to include reinforcement and central recording of this requirement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 30/09/2022 |            |   |            | 29/09/2022 |                                       | Implemented - Final Client Approved                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | All managers have been contacted to ensure that exit procedures adhered to. this process is built into the revised VERS policy which was approved at RTS Committee 1st September 2022 | Exec to review                                                 | Wouldn't look at this as reasonable report and medium priority |
| 111  | Internal Audit | Impact Assessments                                    | 2022 | Reasonable | Medium | Matter Arising 1 – Policies and Procedures (Design of control)                                        | 1.1a: Health Board to clarify and document requirements regarding other Impact Assessments, and ensure information is embedded or signposted in key Health Board policy documentation (e.g. OBS1 Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, and F017 Policy for Revenue Business Case Development), and is accessible and visible to staff developing proposals / policies. Consideration should be given to an intranet page with the relevant resources and expertise signposted for staff. 1.1b Health Board to consider progressing and developing the Impact Assessment Gateway document for strategic and policy decisions including written control documents and development proposals to ensure statutory requirements are met. | 1.1a: The Office of the Board Secretary will review, develop and implement the Impact Assessment Screening Tool (IAST) in consultation with colleagues in strategy and planning, Equalities and other supporting functions. This review will take account of proportionality, recognising that some Impact Assessments are mandatory, some are of a technical nature (e.g. environmental impact assessments) and some are best practice. The review will also consider impact assessments that may become mandatory in the near future, such as the Health Impact Assessment, as well as being mindful of the principles of sustainable development contained within the Wellbeing of Future Generations Act. The review will also be further informed by the report of the Audit Wales review of Equality Impact Assessments across the Welsh public sector which commenced in October 2021 and for which the report is due in summer 2022. Once complete, associated key policies/documentation (Policy on Policies, Policy for Revenue Business Case Development etc.) will be updated to link back to the tool. The IAST will be uploaded to the Health Board's Policies and Procedures page on the staff intranet and can be linked back to from other key sites. The document will be subject to Health Board wide consultation (via the corporate bulletin, "Draft documents for consultation intranet page" and targeted comms) and signed off by the Executive team. | 31/10/2022 | 31/03/2024 | 2 | 29/06/2022 | 30/08/2023 | Implemented - Partial Client Approved | The IAST received final sign off from the Executive Team (25/01/23) and the Health Board Leadership Team (01/02/23) and is now available via the Policies & Procedures page on BetsiNet. Additional targeted comms have been distributed via the Corporate Bulletin, including the offer of training / awareness sessions via OBS attendance at departmental governance meetings. • Confirmation received from the Associate Director of Governance that the EDG ToRs have appropriate narrative regarding impact assessments • Policy on Policies updated to include reference to IAST (draft, pending confirmation of governance structure and then final approval) | Exec to review                                                                                                                                                                        | Wouldn't look at this as reasonable report and medium priority |                                                                |
| 120  | Internal Audit | Financial Management, Reporting and Budgetary Control | 2022 | Reasonable | Medium | Matter Arising 1 - Authorised Virements (Control design)                                              | Finance to ensure that effective manual processes are in place to ensure segregation of duties are being adhered to, including regular sampling of virements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1): E-mail the Divisional Finance Teams to remind them of the importance of following due processes, with the process notes attached for information. (This action has already been carried out). 2): Sample 10% of virements on a month basis to test segregation of duties and authorisation of virements, calling CFO to account for any Breaches within their team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25/06/2022 |            | 0 | 08/06/2022 | 22/08/2023 | Implemented - Partial Client Approved | Sampling of 10% of virements has been built into the regular monthly workflow processes, which incorporates calling CFOs to account for any breaches within their team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Exec to review                                                                                                                                                                        | Wouldn't look at this as reasonable report and medium priority |                                                                |
| 121  | Internal Audit | Financial Management, Reporting and Budgetary Control | 2022 | Reasonable | Low    | Matter Arising 2 - Questionnaire Responses (Operating effectiveness)                                  | Finance to review the findings of the audit questionnaire, and complete the planned rollout of divisional questionnaires commencing March 2022.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1): Finance to review the findings of the audit questionnaire and take on board any feedback. 2): Process for Divisional questionnaires to be sent out March 2022 onwards. This to be via a rolling process of 2 Divisions per month with a sample of 10-20 budget holders per Division. Feedback will be considered and steps taken to address any necessary actions which arise. (Questionnaires have been sent to a sample of budget holders in MH&LD & NWH Division in March and responses are currently being received and co-ordinated).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24/06/2022 |            | 0 | 08/06/2022 | 22/08/2023 | Implemented - Partial Client Approved | Questionnaire responses from the Audit questionnaires and the Finance questionnaires, where these have been received, have been reviewed.. As further responses are received these reviews will continue, and if necessary action plans to address any recurring themes will be drawn up.                                                                                                                                                                                                                                                                                                                                                                             | Exec to review                                                                                                                                                                        | Wouldn't look at this as reasonable report and low priority    |                                                                |
| 127  | Internal Audit | Clinical Audit                                        | 2022 | Limited    | Medium | Matter Arising 1 – Clinical Audit Policy (Operation)                                                  | 1.1: Review and update the policy and procedure document MD22, and include the governance structure within Appendix 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1.1: 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 - 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 and 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.                                                                                                                                                                                                                                                                                      | 30/09/2022 | 30/04/2023 | 5 | 20/04/2023 | 08/08/2023 | Implemented - Partial Client Approved | The policy was approved at EDG (Quality) meeting. The remainder of the process to upload onto the Policies page on the intranet, and link to our Clinical Effectiveness webpage, and for the team to disseminate to local CEGs will now be implemented                                                                                                                                                                                                                                                                                                                                                                                                                | Close                                                                                                                                                                                 | Clinical audit in plan 2024/25                                 |                                                                |

|     |                |                                                       |      |            |        |                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |            |            |   |            |            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                |                                                                |
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| 149 | Internal Audit | Recruitment – Employment of Medical Locum Doctors     | 2022 | Reasonable | High   | Matter Arising 2 – Contract / Performance Management (Design)                   | 2.1: The Health Board ensures there is a robust process to monitor the performance of the contract and this should be reflected in the Health Board Standard Operating Procedure/policy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2.1a: Tripartite Contract Management meetings to be arranged on a monthly basis. 2.1b Senior Contract Management meetings to be held quarterly.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30/06/2022 | 30/05/2024 | 5 |            |            | Implemented - Partial Client Approved | The meetings are now in place and a dashboard is reviewed as part of these meetings which will be revised as required, any issues arising from the performance are discussed and actions agreed to rectify them as part of the contract management oversight.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review |                                                                |
| 165 | Internal Audit | Waste Management                                      | 2022 | Reasonable | Medium | Matter Arising 2 – Non-compliance with Covid-19 operating procedure (Operation) | 2: Recommendations agreed to increase compliance with the Covid-19 SOP should be progressed and reviewed regularly to ensure implementation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2: Estates and Facilities will continue with support from Senior Infection Prevention Leads, to increase compliance with the Covid-19 Standard Operating Procedure which will be reported through Infection Prevention Sub-Group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/08/2022 |            | 0 | 20/09/2022 | 22/08/2023 | Implemented - Partial Client Approved | Compliance with the COVID19 SOP has now been achieved with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 167 | Internal Audit | Speak Out Safely                                      | 2022 | Reasonable | Medium | Matter Arising 1: MDT process log (Design / Operation)                          | 1.1a: Dates to be added into progress log i.e. 'date recorded' 'date of review' to enable tracking of concerns/dates are included. 1.1b: Attendance at MDT meetings to be recorded to demonstrate meetings are accurate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1.1a: To add in details of recommendations in 1.1a: into the MDT process log (process log updated and provided for reference). 1.1b: Full names of attendees at MDT meetings will be captured on the process log (process log updated and provided for reference)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 30/11/2022 |            | 0 | 12/12/2022 | 30/08/2023 | Implemented - Partial Client Approved | Action completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 175 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital | 2022 | Limited    | High   | Matter Arising 5: Risk Management (Operation)                                   | 5.1a: The Risk Register requires review to ensure that risks are accurate and appropriate actions/dates are included. 5.1b: Management to review consistency of reporting in accordance with the revised Operating Model/governance structure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5.1a: EHC Risk Management Group have met twice to date. All level 1 and 2 risk discussed and divisions tasked to review all risks within own areas. Some risks sit within East are corporate risks and some sit within operational estates. Ongoing review of risks, Level 3 – Quarterly, Level 2 – Bi Monthly Level 1 – Monthly. Risks for Acute Site, Childrens, HMP Berwyn, Primary Care, Facilities and Community Services have been amalgamated into an EHC Integrated Risk Meeting, risk register currently under review.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/03/2023 |            | 0 | 30/11/2022 | 05/09/2023 | Implemented - Partial Client Approved | We have fully integrated within the IHC governance framework                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exec to review |                                                                |
| 178 | Internal Audit | Effective Governance - Ysbyty Gwynedd (YG)            | 2022 | Limited    | High   | Matter Arising 3: Clinical audit (Operation)                                    | 3.1a: The list of Tier 3 audits should be shared with the QSCE to ensure there is no duplication of audits/efforts across the Ysbyty Gwynedd. This would also provide opportunities for work across more than one division/locality. 3.1b 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 QSCE and the Clinical Effectiveness Team and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board. 3.1c Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan. | 3.1a: A full list of Tier 3 audits will be Shared via the next Quality Safety and Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focussed and do not duplicate effort. 3.1b Lessons learned from Tier 3 Audits to be a major item from discussion at the December 2022 QSCE, with all Directorates represented on a multi-disciplinary basis to ensure cross fertilisation of ideas and feedback. A report to be produced to consolidate this feedback to be shared via the Health Board level meeting in early 2023. 3.1c All appropriate staff encouraged to participate in Tier 2 audits and contribute to clinical audit, where possible being given allocated time for this, via a joint letter from the clinical members of the new IHC Leadership Team (Medical, Nursing                                                                                                                                                                                                                                                        | 31/12/2022 | 31/03/2023 | 2 | 21/03/2023 | 05/09/2023 | Implemented - Partial Client Approved | Implemented as per update comments 21st March 2023.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review |                                                                |
| 193 | Internal Audit | Charitable Funds                                      | 2022 | Limited    | High   | Matter Arising 1: Information provided to the Board as Trustee (Design)         | 1.1: Induction information provided to Board Members - review and issue to all, to include responsibilities, key information and how they are provided with assurance on the operation of the Charity. 1.2 Review the content and frequency of information provided to Trustees, including: More frequent Board of Trustee meetings. More frequent performance reporting (financial and qualitative, such as achievement of goals and objectives, fundraising data, Charity team activity). Assurance provided on meeting requirements of the Charity Commission. Information on any changes to guidance and how these are being applied within the Charity.                                                                                                                         | 1.1: All Trustees will be reminded of their role and responsibilities and the charity's performance and how to access this information in a Trustees meeting setting. Liaise with the Office of the Board Secretary to review and Charitable Funds information included in induction for Board Members. All Trustees will receive a monthly update from the Charity Support Team on: Information from the Charity Commission to maintain a good level of knowledge and understanding of the Commission's guidance and regulation, and the their role as a Board member of the Corporate Trustee. Spotlight on a Fund and Fund Advisor, so they are aware of the responsibilities and actions of those who are charged with overseeing different funds on behalf of the Corporate Trustee: Updates on grants awarded and grant impact. Review of internal and external communications. 1.2 A review of the content and frequency of information provided to Trustees will be tabled at the Charitable Funds Committee for discussion and reviewed at the Trustee meeting. | 31/01/2023 |            | 0 | 04/05/2023 | 22/08/2023 | Implemented - Partial Client Approved | 1.1 All Trustees will be reminded of their role and responsibilities and the charity's performance and how to access this information in a Trustees meeting setting. Liaise with the Office of the Board Secretary to review and Charitable Funds information included in induction for Board Members. All Trustees will receive a monthly update from the Charity Support Team on: Information from the Charity Commission to maintain a good level of knowledge and understanding of the Commission's guidance and regulation, and the their role as a Board member of the Corporate Trustee. Spotlight on a Fund and Fund Advisor, so they are aware of the responsibilities and actions of those who are charged with overseeing different funds on behalf of the Corporate Trustee. Updates on grants awarded and grant impact. Review of internal and external | Close          | Superseded by 2024 review                                      |
| 198 | Internal Audit | Charitable Funds                                      | 2022 | Limited    | Medium | Matter Arising 6: Expenditure (Design)                                          | 6.1: A process should be put in place to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6.1: A dedicated Grants Manager will be in post by March to ensure a more robust process can be put in place to track funding requests and monitor, evaluate and report funding outcomes and outputs for all charitable activity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/09/2023 | 31/07/2024 | 1 |            |            | Implemented - Partial Client Approved | A dedicated Grants Manager will be in post by March to ensure a more robust process can be put in place to track funding requests and monitor, evaluate and report funding outcomes and outputs for all charitable activity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Close          | Superseded by 2024 review                                      |
| 199 | Internal Audit | Charitable Funds                                      | 2022 | Limited    | High   | Matter Arising 7: Charity Objectives (Operation)                                | 7.1: The wording of the Charity's objectives should be reviewed to ensure it accurately reflects the spend of the charity i.e. staff and wellbeing support initiatives.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7.1: The charity objectives will be updated to ensure clarity of purpose in the 2023-28 strategy, due to be presented for approval at the December 2022 Charitable Funds Committee meeting, and ratification at the January 2023 Trustees meeting. The objectives will then be updated on the Charity Commission website, intranet, internet and the BCUHB Charitable Funds webpage.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31/01/2023 |            | 0 | 24/04/2023 | 22/08/2023 | Implemented - Partial Client Approved | The charity objectives will be updated to ensure clarity of purpose in the 2023-28 strategy, due to be presented for approval at the December 2022 Charitable Funds Committee meeting, and ratification at the January 2023 Trustees meeting. The objectives will then be updated on the Charity Commission website, intranet, internet and the BCUHB Charitable Funds webpage.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Close          | Superseded by 2024 review                                      |



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| 204 | Internal Audit | Management of utility usage, expenditure and efficiency | 2022 | Substantial | Medium | Matter Arising 1: Data input to the EFPMS system is comparable in performance to other Health Boards across Wales (Operation) | Management to identify what actions are required to reduce consumption in the sites identified in order to meet the all Wales KPI for net energy consumption. Where actions are already planned i.e. as part of the Decarbonisation Energy plan, this should be clearly stated.                                                                                                                                                   | Operational Estates are working in partnership with Local Partnerships, Welsh Government Energy Services and Re-Fit Cymru in developing a framework to deliver the Health Board's Decarbonisation Action Plan relevant to Buildings. The framework will look at opportunity to invest in self generating energy sources i.e. Solar PV and energy reduction project by upgrading existing engineering infrastructure i.e. LED Lighting, HVAC etc. The project will be delivered over 2 phases with an estimated completion date for the framework by 2030.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 30/06/2023 |  | 0 | 30/06/2023 | 22/08/2023 | Implemented - Partial Client Approved | Operational Estates are working in partnership with Local Partnerships, Welsh Government Energy Services and Re-Fit Cymru in developing a framework to deliver the Health Board's Decarbonisation Action Plan relevant to Buildings. The framework will look at opportunity to invest in self generating energy sources i.e. Solar PV and energy reduction project by upgrading existing engineering infrastructure i.e. LED Lighting, HVAC etc. The project will be delivered over 2 phases with an estimated completion date for the framework by 2030.                                                                                                                                                                                                                                                                                                                                    | Exec to review | Wouldn't look at this as substantial report and low priority |
| 205 | Internal Audit | Mental Health & Learning Disabilities Division          | 2023 | Reasonable  | High   | Matter Arising 1: The MHLD Improvement Plan (Operation)                                                                       | Further progression is needed in order to achieve the overall divisional completion target of 85%. Focus is necessary to increase the uptake of training within areas of the division                                                                                                                                                                                                                                             | Divisional PADR compliance rates to be an Agenda item in all local Operational Delivery meetings, with focus on staff who have - Never had a PADR (as at 31 st January 35 Divisional staff recorded); Never has a PADR Starter (as at 31st January 43 Divisional staff recorded); Out of date 24+months (as at 31 st January 4% (n76) noted). To ensure the Division meets the target compliance of 85% by 31/5/2023. Business Support Managers to include a detailed analysis of area PADR compliance data in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss PADR compliance rates during local area Operational Delivery meeting, identify any barriers and support needed to ensure compliance of 85% is met by 31/5/2023 across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include PADR compliance rates, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting (formally DSLT Finance and Performance meeting, Tier 2) to monitor and review progress. The Divisional Key Performance Indicators aligned to PADR to be scrutinised and any additional intervention discussed and agreed for areas under achieving. Reaffirm importance of and recording of PADRs within the MH&LD Staff Briefing. Include monthly PADR compliance rates in the Divisional Improvement Plan KPI data to show trajectory of improvement. WARRN TRAINING. Identify and book alternative accommodation to enable WARRN training sessions to accommodate 25 staff, instead of current 15 staff, to enable an increase in numbers of staff trained each month in order to increase training compliance from 62.5% to 85% by 30/9/2023. Provide monthly WARRN training compliance data, including analysis of individual area/department compliance, to HSE NOC Delivery Group meeting to enable monitoring, review and early identification of any barrier to delivery of meeting compliance target rate of 85% by 30/9/2023. Continue with delivery of twice monthly WARRN training sessions to ensure an additional 200 divisional staff complete WARRN training to meet 85% compliance. Set up a process to ensure new starters in the MH&LD Division are included in the monthly WARRN training sessions. | 30/04/2023 |  | 0 | 26/06/2023 | 31/08/2023 | Implemented - Partial Client Approved | Divisional PADR compliance rates to be an Agenda item in all local Operational Delivery meetings, with focus on staff who have - Never had a PADR (as at 31 st January 35 Divisional staff recorded). Never has a PADR Starter (as at 31st January 43 Divisional staff recorded) Out of date 24+months (as at 31st January 35 Divisional staff recorded) PADR completed but not recorded (as at 31st January 4% (n76) noted). To ensure the Division meets the target compliance of 85% by 31/5/23. Business Support Managers to include a detailed analysis of area PADR compliance data in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss PADR compliance rates during local area Operational Delivery meeting, identify any barriers and support needed to ensure compliance of 85% by 31/5/23 across all | Exec to review |                                                              |
| 212 | Internal Audit | Digital Strategy                                        | 2023 | Reasonable  | High   | Matter Arising 1: Funding the implementation of the Digital Strategy (Operation)                                              | The Chief Digital and Information Officer, working with Finance colleagues: <ul style="list-style-type: none"> <li>identifies the costs associated in implementing the digital strategy.</li> <li>ensures the budget report accurately reflects the funded establishment.</li> <li>where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee.</li> </ul> | 1. Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPPH that includes the details about unfunded projects and the risks association with stopping those.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 30/06/2023 |  | 0 | 30/06/2023 | 15/08/2023 | Implemented - Partial Client Approved | Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPPH that includes the details about unfunded projects and the risks association with stopping those. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Exec to review |                                                              |



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| 215  | Internal Audit | Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved | 2023 | Limited    | Medium | Matter Arising 3: Data Reconciliation (Operation)                                | 3.1: Management to ensure reconciliation of reported performance information to source data is documented and retained. This could be incorporated within existing working documents. 3.2 Health Board to consider using UPCC engagement data to target promotion of the service to GP Practices that have low referral rates / have not used the service.                                                                                                            | 3.1: Review of reconciliation data for West and inaccuracies corrected. Confirm management arrangements for reconciliation and retention of performance data for Central IHC UPCC in line with findings and recommendations. Please refer to UPCC Peer review Action Plan – IA2. 3.2 Continuous review of GP practices that have not used the service and meetings/discussions to take place where necessary. Continuous attendance at Practice Managers/Cluster Meetings to promote and provide update of engagement. Review of ED referrals in the West to understand limitations, and consider relocation if proximity to ED is identified as an issue. Please refer to UPCC Peer review Action Plan – IA2                                                                                                                                                                                                                                                                                | 31/05/2023 | 30/04/2024 | 1 |            |            | Implemented - Partial Client Approved | 3.1 Review of reconciliation data for West and inaccuracies corrected. Confirm management arrangements for reconciliation and retention of performance data for Central IHC UPCC in line with findings and recommendations. Please refer to UPCC Peer review Action Plan – IA2. 3.2 Continuous review of GP practices that have not used the service and meetings/discussions to take place where necessary. Continuous attendance at Practice Managers/Cluster Meetings to promote and provide update of engagement. Review of ED referrals in the West to understand limitations, and consider relocation if proximity to ED is identified as an issue. Please refer to UPCC Peer review Action Plan – IA2 | Exec to review |                                                                |
| 1260 | Internal Audit | Digital Strategy                                                                | 2023 | Reasonable | High   | Matter Arising 1: Funding the implementation of the Digital Strategy (Operation) | The Chief Digital and Information Officer, working with Finance colleagues: <ul style="list-style-type: none"> <li>identifies the costs associated in implementing the digital strategy.</li> <li>ensures the budget report accurately reflects the funded establishment.</li> <li>where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee.</li> </ul>                                     | 2. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30/06/2023 |            | 0 | 30/06/2023 | 15/08/2023 | Implemented - Partial Client Approved | Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPPH that includes the details about unfunded projects and the risks association with stopping those. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24.                                                                                                                                                                                                                                                                                                   | Exec to review |                                                                |
| 114  | Internal Audit | Standards of Business Conduct - 2022                                            | 2022 | Limited    | High   | Matter Arising 3: Declarations of Interest Compliance (Operation)                | 3.1: Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required. 3.2: The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.                                                                                                                                                                                                        | 3.1: Governance Leads will be issued monthly reports highlighting their teams’ compliance with DOI submissions, which will form part of their monthly governance meetings, and escalated to the appropriate Execs Delivery Group on a bi-monthly basis. 3.2: An automated approach to DOI management is being pursued via the MES Declare system, with the aim of ensuring that this is in place from the 1 st of April 2022. This will also be supported by a communications plan and a refreshed FAQ page. 3.3: As part of the planned communications plan, staff will be reminded of their obligations to disclose gifts and hospitality offered and received (onto the MES Declare system) under the Standards of Business Conduct Policy. This will also feed into the assurance monitoring by governance leads, which will include pursuing unauthorised declarations and escalate non-compliance of staff for known Gifts and Hospitality received, but which they have not declared. | 30/06/2022 | 31/01/2024 | 3 | 23/06/2022 | 09/02/2024 | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Close          | Superseded by 2024 review                                      |
| 116  | Internal Audit | Standards of Business Conduct - 2022                                            | 2022 | Limited    | High   | Matter Arising 2: Declarations of Interest system (Operation)                    | 2.1: The Office of the Board Secretary should seek confirmation from Finance that this information has been updated on a regular basis, to ensure compliance can be accurately monitored. 2.2: Exception reporting should be produced and reviewed regularly to highlight any issues with the data and the impact on compliance rates.                                                                                                                                | 2.1: Agreed, however a new system is being put in place with effect from April 2022, which will be managed directly by the Office of the Board Secretary, and monthly updates from ESR will be incorporated onto the MES Declare system to ensure its accuracy and completeness. 2.2 Exception reports will be generated on a monthly basis on the new system, and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30/06/2022 | 31/01/2024 | 3 | 08/07/2022 | 09/02/2024 | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Close          | Superseded by 2024 review                                      |
| 117  | Internal Audit | Standards of Business Conduct - 2022                                            | 2022 | Limited    | Medium | Matter Arising 4: Gifts and Hospitality requirements (Operation)                 | 4.1: The guidance regarding the process of accepting/ declaring gifts as well as Hospitality should be circulated/highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors/Assistant Directors of their role in approving hospitality prior to acceptance. | 4.1: Agreed, a communications plan will be put in place to publicise the importance of disclosure of gifts and hospitality as part of the process of raising awareness on the requirements of the Standards of business Conduct Policy. (Consideration is also being given in relation to making the process of accepting / declaring gifts as well as Hospitality and the submission of an annual declaration of interests (even a Zero return), to be recorded as part of employees ’ Annual appraisal process. The level of compliance can then be monitored from the systems where the Annual Assessment or PADR is recorded. The feasibility of this approach is being considered.)                                                                                                                                                                                                                                                                                                     | 30/06/2022 | 31/01/2024 | 2 | 15/09/2022 | 09/02/2024 | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Close          | Superseded by 2024 review                                      |
| 118  | Internal Audit | Standards of Business Conduct - 2022                                            | 2022 | Limited    | High   | Matter Arising 5: Monitoring and reporting arrangements (Design)                 | 5.1: The Office of the Board Secretary to consider the monitoring arrangements in place for declarations, gifts and hospitality to ensure these are reviewed on a regular basis. 5.2: Reporting to the Audit Committee to be updated to include current compliance rates for DOIs. Consideration should be given to more regular reporting if compliance rates are generally low.                                                                                     | 5.1: DOI monitoring will take place monthly with scope incorporating: <ul style="list-style-type: none"> <li>The completeness of the disclosures for decision makers</li> <li>Quality assurance checks on submissions</li> <li>Significantly out of date disclosures requiring escalation</li> <li>Monthly update of ESR starters and leavers data</li> <li>DOI disclosures requiring follow-up action</li> <li>Gifts and hospitality declaration monitoring</li> </ul> Where appropriate, Governance Leads will also be assigned the same responsibilities for DOI reports to be monitored by the Office of the Board Secretary on a bi-monthly basis, with compliance rates to be reported to Audit Committee on a quarterly basis, by the Office of Board Secretary.                                                                                                                                                                                                                      | 31/05/2022 | 31/01/2024 | 3 | 29/06/2022 | 09/02/2024 | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Close          | Superseded by 2024 review                                      |
| 119  | Internal Audit | Integrated Service Boards Governance                                            | 2022 | Limited    | High   | Matter Arising 1 – ISB Governance Arrangements (Operation)                       | The Health Board ensures Integrated Service Board governance arrangements are aligned with its own governance and planning frameworks, and is subject to regular review and scrutiny.                                                                                                                                                                                                                                                                                 | This action will be addressed as part of the review of the key documents supporting the embedding of the new Operating Model. These documents are the Scheme of Reserved Delegation development, the Performance and Accountability Framework, as well as the risk management policy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30/06/2022 | 30/09/2023 | 4 | 15/07/2022 | 25/10/2023 | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Exec to review |                                                                |
| 148  | Internal Audit | Recruitment – Employment of Medical Locum Doctors                               | 2022 | Reasonable | Medium | Matter Arising 1 – Justification Notes (Operation)                               | 1.1: All requests for recruitment of locum medical staff should be completed to a good level and include all necessary information and justification notes, which will facilitate an effective audit trail.                                                                                                                                                                                                                                                           | 1.1a: Clear guidance on minimum information required to be developed in liaison with Finance and Associate Medical Director Professional Standards (Office of the Medical Director ‘OMD’). 1.1b Quarterly compliance audit will be undertaken by WOD/Fin/OMD and included in Contract management information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30/06/2022 | 29/02/2024 | 6 |            |            | Started                               | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Exec to review | Wouldn't look at this as reasonable report and medium priority |

|     |                |                                                                      |      |            |        |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |            |            |   |  |  |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                                |
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| 194 | Internal Audit | Charitable Funds                                                     | 2022 | Limited    | High   | Matter Arising 2: Charitable Funds Committee (Operation)                   | 2.1: Review Membership of the Charitable Funds Committee in light of Executive changes, including the quoracy required for meetings and update Terms of Reference to reflect any revisions. We suggest a minimum 2 Executives and 2 Independent Members, recognising the wider pool of IM and Executives who are Board of Trustee Members. 2.2: Review responsibilities and objectives of Committee and consider the regular information provided including more qualitative data on the operation of the Charity, updating the Terms of Reference to reflect any revisions. 2.3: Undertake a review of the effectiveness of the Charitable Funds Committee, in line with the requirements of the Terms of Reference (2.1) of the Committee, including requirements of the Charity Commission. | 2.1: New Terms of Reference to be approved by the BCUHB Chairman, the Chair of the Charitable Funds Committee and the Executive Team and submitted for approval by the Charitable Funds Committee and ratified by the Trustee Board. 31/01/23 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to all Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate. 31/01/23 Interim Board Secretary: 2.3 Undertake an effectiveness review of the Committee via survey/interview of all Committee members and non-member regular attendees, and commit to a plan for reporting this and scheduling it in on an annual basis. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item.                                                                                                                                                                                                                                                                                                                     | 31/01/2023 | 31/03/2024 | 2 |  |  | Started | 2.1 New Terms of Reference to be approved by the BCUHB Chairman, the Chair of the Charitable Funds Committee and the Executive Team and submitted for approval by the Charitable Funds Committee and ratified by the Trustee Board. 31/01/23 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to all Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate. 31/01/23 Interim Board Secretary. 2.3 Undertake an effectiveness review of the Committee via survey / interview of all Committee members and non-member regular attendees, and commit to a plan for reporting this and scheduling it in on an annual basis. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item.                                                                                                                                                                                                                                                                                                                   | Close          | Superseded by 2024 review                                      |
| 207 | Internal Audit | Mental Health & Learning Disabilities Division                       | 2023 | Reasonable | Medium | Matter Arising 3: Appropriate governance arrangements in place (Operation) | 3.1a (i) The division to review ToRs for meetings to ensure these are in place, dated and approved.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3.1a (i): Review TOR's highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Summit meeting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30/04/2023 | 31/05/2024 | 3 |  |  | Started | Review TOR's highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Summit meeting, MH&LD Finance and Performance Group MH&LD Clinical Strategy Group. To ensure, upon agreement of the revised Cycle of Business, all TOR's are reviewed aligned to agreed Governance Framework of the new MH&LD Operating Model. Formal reporting throughout all meeting tiers to be implemented, with all meeting Agenda's amended aligned to agreed reporting structure. MH&LD Cycle of Business populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chairs Assurance reports template or Exceptions report template included for reporting throughout Tiered governance framework structure.                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 222 | Internal Audit | Follow up – Audit Wales: Effectiveness of Counter Fraud Arrangements | 2022 | Reasonable | Medium | Matter Arising 2: Recommendation 2 – Fraud Risks (Operation)               | Current ownership of fraud risks is reviewed and transferred for operational management and control where appropriate. The Counter Fraud Team works in partnership with the Risk Management Department to embed operational services ownership and identification of fraud risk in their day-to-day processes and any risks specific to the Counter Fraud team are reviewed on a regular basis.                                                                                                                                                                                                                                                                                                                                                                                                | The Director of Finance: Operational Finance has directed the Head of the Health Board's Local Counter Fraud Service to work with the Associate Director of Governance to agree the Agreed Management Action. Whilst the actions have individual action owners, the Associate Director of Governance will take responsibility to make sure they have been completed. Discussions have taken place with the Associate Director of Governance during November 2022 and have initially focused on the Management Actions which are required to be undertaken, to mitigate the Counter Fraud risks, to an acceptable level to achieve the Target Risk score – to allow the risks to be closed on the Risk Management system. The Associate Director of Governance will be tabling this at the BCUHB Risk Management Agenda Item in the BCUHB Health Board Leadership Team in January 2023 and the Risk Management Group in February to check and confirm that all actions have been taken. Associate Director of Governance to formally report to Audit Committee on a quarterly basis on the number of Fraud Risks which are being recorded by each of the Health Boards operational service departments. | 31/12/2022 | 06/12/2023 | 2 |  |  | Started | The Director of Finance: Operational Finance has directed the Head of the Health Board's Local Counter Fraud Service to work with the Associate Director of Governance to agree the Agreed Management Action. Whilst the actions have individual action owners the Associate Director of Governance will take responsibility to make sure they have been completed. Discussions have taken place with the Associate Director of Governance during November 2022 and have initially focused on the Management Actions which are required to be undertaken, to mitigate the Counter Fraud risks, to an acceptable level to achieve the Target Risk score – to allow the risks to be closed on the Risk Management system. The Associate Director of Governance will be tabling this at the BCUHB Risk Management Agenda Item in the BCUHB Health Board Leadership Team in January 2023 and the Risk Management Group in February to check and confirm that all actions have been taken. Associate Director of Governance to formally report to Audit Committee on a quarterly basis on the number of Fraud Risks which are being recorded by each of the Health Boards operational service departments. | Exec to review | Wouldn't look at this as reasonable report and medium priority |

|     |                |                                                                                                      |      |         |      |                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |            |   |  |  |         |           |                |                                |
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| 158 | Internal Audit | On-Call arrangements                                                                                 | 2022 | Limited | High | Matter Arising 1 – Review of on-call arrangements (Design)                                                                                     | 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.                                                                                                             | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 23/09/2022 | 01/06/2024 | 3 |  |  | Pending | No update | Exec to review |                                |
| 159 | Internal Audit | On-Call arrangements                                                                                 | 2022 | Limited | High | Matter Arising 2 – Rota guidance / sustainability (Design)                                                                                     | The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; 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.                                                                                                                                       | 2.1: On-call document, covering the recommendations above will be issued to all staff.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01/07/2022 | 01/06/2024 | 1 |  |  | Pending | No update | Exec to review |                                |
| 160 | Internal Audit | On-Call arrangements                                                                                 | 2022 | Limited | High | Matter Arising 3 – Compensatory rest and payment (Operation)                                                                                   | Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. 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.                                                                                                                                                                                                                          | 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. <i>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.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11/07/2022 | 01/06/2024 | 1 |  |  | Pending | No update | Exec to review |                                |
| 161 | Internal Audit | On-Call arrangements                                                                                 | 2022 | Limited | High | Matter Arising 4 – Training (Design)                                                                                                           | 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.                                                                                                                                                                                                        | 4.1a: Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28/09/2022 | 01/06/2024 | 1 |  |  | Pending | No update | Exec to review |                                |
| 169 | Internal Audit | Comisiynydd y Gymraeg / Welsh Language Commissioner: Dogfennau ar y Wefan / Documents on the Website | 2022 | Limited | High | Matter Arising 1: There is an effective process in place for the management of Welsh information on the external Health Board website (Design) | 1.1: Health Board to establish formal policy to support the management of the Health Board website (and other digital) content. 1.2: Management review website user administrator access privileges and establish controls to ensure amendments or additions to the Health Board website are subject to review and scrutiny prior to publishing. 1.3: Management to establish controls or monitoring arrangements to ensure that changes published on the English web pages are also actioned on the Welsh pages.                                                                                                                                                                                                     | 1.1: Establish a formal policy and guidance to support the management of BCU digital channels, including the website. 1.2a: Review current administration access to the BCU website and issue revised guidance and training where required. 1.2b: Commission support to conduct a review of the website to identify and rectify any discrepancies with existing Welsh/English content. This will be a six-month project to provide a robust review of the website. This will be funded by the Corporate Communications Team. 1.2c: Recruit a dedicated translator for the Corporate Communications Team to: manage all translation requests for the website ensure content is published simultaneously link with Welsh Language team to maintain translation standards. This will ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. The funding for the first 12 months of the post has been agreed, during which time a business case will be made for the post to be permanently established within the team. 1.2d: All devolved editors will be contacted and reminded about the translation and publication requirements for the website and offered refresher training sessions. 1.3a: Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website and resolve issues with delayed translation requests. 1.3b: Establish a programme of audits to monitor the website on a monthly basis. | 31/03/2023 | 31/01/2024 | 4 |  |  | Pending | No update | Close          | superseded by follow up review |
| 170 | Internal Audit | Comisiynydd y Gymraeg / Welsh Language Commissioner: Dogfennau ar y Wefan / Documents on the Website | 2022 | Limited | High | Matter Arising 2: The Health Board complies with the requirements of the Standards (Design)                                                    | 2.1a: The Health Board must comply with the requirements of the Welsh Language Standards and ensure that information published on its website is consistent on both Welsh and English platforms. Controls to be implemented to ensure that the Welsh language is treated no less favourably than the English language. 2.1b: Digital Communications Team to address the issues identified and review the Welsh website regularly to ensure consistency with the English website.                                                                                                                                                                                                                                      | 2.1a: In response to recommendations 1.1, 1.2 and 1.3 recommendations have been made to resolve the current risk of non-compliance. These include: Establish a formal policy and guidance to support the management of BCU digital channels, including the website. Review current administration access to the BCU website and issue revised guidance and training where required. Recruit a dedicated translator for the Corporate Communications Team to manage all translation requests for the website, which will ensure content is published simultaneously and ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. 2.1b: Issues identified with the audited web pages that are managed by the Corporate Communications Team have been resolved. 2.1b: Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website. 2.1b: Establish a regular programme of audits with the Welsh Language Team to monitor the website on a monthly basis. 2.1b: The Board Secretary to review and resolve issues relating to the publication of inconsistent Board/Committee papers and bundles.                                                                                                                                                                                                                                                                                                          | 31/12/2022 | 30/09/2023 | 3 |  |  | Pending | No update | Close          | superseded by follow up review |
| 172 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital                                                | 2022 | Limited | High | Matter Arising 2: Finance (Operation)                                                                                                          | 2.1a Management to identify and progress savings schemes as a matter of urgency. 2.1b Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2.1a A revised control total has been set for the EIH. E IHC is an exemplar area for CHC savings. 2.1b The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/03/2023 | 05/02/2024 | 1 |  |  | Pending | No update | Exec to review |                                |
| 173 | Internal Audit | Effective Governance - Ysbyty Wrexham Maelor Hospital                                                | 2022 | Limited | High | Matter Arising 3: Clinical audit (Operation)                                                                                                   | 3.1a: The list of Tier 3 audits should be shared with the East Clinical Effectiveness Group to ensure audits are focused on the risks within the site and that there is no duplication of audits/efforts across the site. This would also provide opportunities for work across more than one division/locality. 3.1b: Results and lessons from Tier 3 audits should documented and 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 East Clinical Effectiveness Group and a process put in place to ensure that relevant learning/ feedback is shared across the site and potentially the Health Board. | 3.1a and 3.1b The East Clinical Effectiveness Group is established in the new governance plan and includes both the YWM and Community Services Medical Directors, so is already happening. The Director of Nursing for East chairs this and the T3 audits are shared in this forum, as are the results and recommendations. The imminent commencement of a newly appointed EHC Medical Director will enable, as part of the wider team, a robust, structured approach to developing and delivering the action plans.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 23/11/2022 | 28/02/2025 | 2 |  |  | Pending | No update | Exec to review |                                |

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| 183 | Internal Audit | Board and Committee Reporting | 2022 | Limited    | High   | Matter Arising 1: Request and submission of papers and reports (Design)                | 1.1: We recognise that the Health Board have recently implemented a Board/Committee Paper Assurance and Publication SOP. Management to ensure established timescales are met, monitor compliance, and escalate issues of significance to relevant Executive Leads, Chairs, and/or Board Secretary. 1.2 Management to consider publishing meeting and committee calendar on the Health Board website to encourage public engagement.                                                                                                                                                                                                                                                                                                             | 1.1: Agreed and as stated a Standard Operating Procedure for committee and board agendas is in place. 1.2 2023/24 Board and Committee meeting calendar will be published when finalised.                                                                                                                                                                                                                                                                                                                                                                                     | 31/12/2022 | 31/03/2024 | 2 | 31/01/2024 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review |                                                                |
| 184 | Internal Audit | Board and Committee Reporting | 2022 | Limited    | High   | Matter Arising 2: Submitted papers meet the Board / Committee requirements (Operation) | 2.1: Management to ensure that papers and reports submitted to the BCU Board, Committees, or Advisory Groups are of the expected standard, meet the requirements of the Board / Committee and have been reviewed and quality checked prior to being submitted. Submissions to comply with Board / Committee Paper Assurance and Publication SOP. 2.2 Health Board to consider undertaking a root cause analysis of Board and Committee paper and report quality to determine whether there are underlying factors impacting the frequency of issues raised and determine appropriate solutions.                                                                                                                                                 | 2.1: We will put in place three line of defence processes in assurance reporting, which will enable more focus on the requirements of the Board and its Committees, as well as the evidence required at an executive level to enable robust reports to be produced. This will also be incorporated within the Board and Committee effectiveness review and incorporated within the overall action plan, which be aligned to the Board development programme. 2.2 Accepted, root cause analysis to be undertaken as a result of the Board and Committee effectiveness review. | 30/03/2023 | 29/02/2024 | 1 |            |            | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review |                                                                |
| 185 | Internal Audit | Board and Committee Reporting | 2022 | Limited    | High   | Matter Arising 3: Reporting Breaches (Design)                                          | 3.1: Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3.1: All staff will be reminded of the requirement to complete the breach log in relevant cases. Internal Audit observation: We do not believe the management action mitigates the risk of inaccurate reporting to Audit Committee.                                                                                                                                                                                                                                                                                                                                          | 31/12/2022 | 31/12/2023 | 1 | 31/11/2023 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review |                                                                |
| 186 | Internal Audit | Board and Committee Reporting | 2022 | Limited    | High   | Matter Arising 4: Cycles of Business and Terms of Reference (Operation)                | 4.1: Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed and approved by relevant committees to ensure continued relevance. Approval should be recorded in relevant meeting minutes. 4.2 Management to consider publishing Board/Committee Terms of Reference and/or Cycles of Business on the Health Board website to promote public engagement and reintroduce the publishing of meeting minutes to improve accessibility.                                                                                                                                                                                                                                                                    | 4.1: Agreed. The ToR approved by Board in the September 2021 governance review are in the process of being reviewed and proposed to the committees and their approval will naturally be minuted. Committee Terms of reference will also be reviewed as part of the Board and Committee effectiveness review. 4.2 Agreed, these will be published on the website.                                                                                                                                                                                                             | 30/03/2023 | 31/12/2023 | 1 | 28/03/2024 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review |                                                                |
| 187 | Internal Audit | Chairs action                 | 2022 | Reasonable | High   | Matter Arising 1: Process Design (Design)                                              | 1.1: Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally/request made to OBS/authorisation granted by IMs and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted. | 1.1: The template will be amended as suggested to include the five additional fields.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 31/01/2023 | 29/02/2024 | 1 | 30/09/2023 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review |                                                                |
| 188 | Internal Audit | Chairs action                 | 2022 | Reasonable | Medium | Matter Arising 2: Standard Operation Procedure (SOP) (Operation)                       | 2.1: SOP should be updated to reflect the detail of the process in place and consideration given to which IMs should be included in the approval of the request, where possible using their area of expertise                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2.1: The SOP will be updated to ensure alignment with the current practice for Chairs Actions, including the criteria applied for Independent member selection, taking into account expertise, and appropriate committee remit                                                                                                                                                                                                                                                                                                                                               | 30/11/2022 | 29/02/2024 | 1 | 25/03/2024 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 189 | Internal Audit | Chairs action                 | 2022 | Reasonable | Medium | Matter Arising 3: Information provided to members / committees (Design)                | 3.1: All Board/Committee members should have access to the information provided with the request to ensure transparency and further scrutiny.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3.1: Investigate a SharePoint site for Chair's Actions which will enable all Chair's Actions to be reviewed by all IMs should they wish to do so.                                                                                                                                                                                                                                                                                                                                                                                                                            | 31/01/2023 | 29/02/2024 | 1 |            |            | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 190 | Internal Audit | Chairs action                 | 2022 | Reasonable | Medium | Matter Arising 4: Lessons Learned (Design)                                             | 4.1: There should be a periodic review of Chair's actions to determine the reason for the action and to establish if any changes need to be made to current processes/approval routes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4.1: The Board Secretary and Head of Corporate Affairs to review on a Yearly basis the Chair's Actions brought throughout the year.                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/01/2023 | 29/02/2024 | 1 |            |            | Pending | No update                                                                                                                                                                                                                                                                                                                                                | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 195 | Internal Audit | Charitable Funds              | 2022 | Limited    | High   | Matter Arising 3: Strategy (Operation)                                                 | 3.1: The Charity Strategy should be presented to Board of Trustees for review and approval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3.1: Charity Strategy to be submitted for approval to the December 2022 Charitable Funds Committee and presented for ratification at the January 2023 Trustees meeting.                                                                                                                                                                                                                                                                                                                                                                                                      | 31/01/2023 | 31/03/2024 | 2 |            |            | Pending | Charity Strategy to be submitted for approval to the December 2022 Charitable Funds Committee and presented for ratification at the January 2023 Trustees meeting.                                                                                                                                                                                       | Close          | superseded by 2024 revuiew                                     |
| 196 | Internal Audit | Charitable Funds              | 2022 | Limited    | Medium | Matter Arising 4: Policies and procedures (Design)                                     | 4.1: Policies and procedures are reviewed to ensure any changes are reflected. Feedback from the Fund Advisor questionnaire should be incorporated when reviewing the procedures. 4.2 Training for Fund Advisors is reviewed and recommences as soon as possible.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4.1: Financial Procedures to be reviewed and submitted to the Charitable Funds Committee in March 2023 for approval. Engagement and Communications Procedures to also be drawn up for approval by the Charitable Funds Committee in March 2023. 4.2 New Fund Advisor training package and communications plan to be in place and resourced by April 2023.                                                                                                                                                                                                                    | 30/04/2023 | 31/07/2024 | 2 |            |            | Pending | 4.1 Financial Procedures to be reviewed and submitted to the Charitable Funds Committee in March 2023 for approval. Engagement and Communications Procedures to also be drawn up for approval by the Charitable Funds Committee in March 2023. 4.2 New Fund Advisor training package and communications plan to be in place and resourced by April 2023. | Close          | superseded by 2024 revuiew                                     |

|     |                |                                                |      |              |      |                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                      |            |            |   |  |            |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                |
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| 202 | Internal Audit | Delivery of Health Board Savings               | 2023 | No assurance | High | Matter Arising 3: Effective governance and oversight arrangements to deliver savings (Design)               | 3.1a The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes.                                                                                                                                                                                                                                                                                               | 3.1a: The targeted delivery of operational savings has been progressed within the Health Board and delivered for the 2023/24 financial year.                                                         | 30/04/2023 |            | 0 |  | 25/10/2023 | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Close          | superseded by follow up review |
| 203 | Internal Audit | Delivery of Health Board Savings               | 2023 | No assurance | High | Matter Arising 4: Transformational Savings and the establishment of the Transformational Team (Operation)   | 4.1a <i>(listed as 3.1a in the Audit Report)</i> The Health Board: <ul style="list-style-type: none"> <li>Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings.</li> <li>Reviews the role of the Transformational Team in driving service change and savings.</li> </ul> | 4.1a: <i>(listed as 3.1a in the Audit Report)</i> Work continues on development and ownership of transformational savings for the 2024/25 financial year and beyond (as part of planning formation). | 30/04/2023 | 31/07/2024 | 1 |  |            | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Close          | superseded by follow up review |
| 206 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable   | High | Matter Arising 2: Ligature remediation funding (Operation)                                                  | 2.1a MHLd management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.                                                                                                                                                                                                                                                                                  | 2.1a: Each MH&LD SLT to establish a local Ligature Reduction Group, chaired by the Head of Operations, Vice Chair Head of Nursing with an agreed standardised TOR signed of.                         | 30/04/2023 | 30/07/2024 | 3 |  |            | Pending | Each MH&LD SLT to establish a local Ligature Reduction Group, chaired by the Head of Operations, Vice Chair Head of Nursing with an agreed standardised TOR signed of. To review TOR of the newly established Divisional Ligature Reduction Group, to ensure appropriate membership, meeting frequency and reporting of the group is discussed, agreed and signed off. The Chair of each MH&LD local Ligature Reduction Group to provide an exception report to the Divisional Ligature Reduction Group, covering the following: annual review status evidence of monthly review risk control and mitigation progress aligned to external review recommendations. The Chair of the Divisional Ligature Reduction Group to provide an exception report to the MH&LD Divisional Service Quality Group (formally MH&LD QSE meeting, Tier 2) and to the MHLd Senior Leadership                 | Exec to review |                                |
| 208 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable   | High | Matter Arising 4: Issues identified relating to the workforce within MHLd have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management.                                                                                                                                                                                                                    | 4.1: Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting.                  | 30/06/2023 |            | 0 |  | 31/08/2023 | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and any additional | Exec to review |                                |

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| 209 | Internal Audit | Follow up - Audit Wales: Continuing Healthcare Arrangements Repor | 2022 | Reasonable | Medium | Matter Arising 1: CHC Training Programme (Operation)                     | 1.1a The CHC Team, working with colleagues in Health Communities/ Divisions/Pan-North Wales services agree a method to capture training needs analysis information upon which directed training can be planned and delivered.                                                                                                                             | 1.1a: <ul style="list-style-type: none"> <li>Complete Learning Needs Analysis to identify training requirements and support the basis for planning further training activities, education approaches and methods; Learning Needs Analysis will expand on the Education Strategy and be coordinated through the CHC Strategic Joint Education Group (with LA partners). Mapping of training will capture relating framework, such as 117 aftercare.</li> <li>Innovative approaches to be considered and agreed (for CHC and Broadcare training) include multi-choice quizzes at the end of training modules, training videos, online feedback, Webinars, BetsiNet Newsfeed; continue to work with ESR to further develop accessible electronic CHC training modules;</li> <li>Improved data collection through group discussions, training needs assessment questionnaires/rolling review of feedback forms and surveys, skills and knowledge analysis, observations from lessons learned;</li> <li>Develop CHC Competency Framework by end of March 2023 with ambition to implement summer of 2023. CHC covers a diverse and specialised range of skills and the Framework will identify skills and knowledge required;</li> <li>Explore training appraisals within PADR's and make recommendations to the operational teams for implementation.</li> <li>Implement training module to communicate Lessons Learned from Appeals and Retrospective Claims to the wider Health and Social Care system; coordinate through the CHC Strategic Joint Education Group;</li> <li>Share training attendance registers with operational line managers across the wider Health Board to address any issues of non-attendance and develop an action plan;</li> <li>Embed CHC Foundation module into core 'business as usual' training as part of the 2023 rolling training programme; the Foundation module will be delivered on a monthly basis from January 2023 and publicised via the BetsiNet CHC page and via the CHC Strategic Joint Education Group.</li> </ul> | 31/03/2023 | 01/09/2023 | 1 |  | 28/11/2023 | Pending | Complete Learning Needs Analysis to identify training requirements and support the basis for planning further training activities, education approaches and methods; Learning Needs Analysis will expand on the Education Strategy and be coordinated through the CHC Strategic Joint Education Group (with LA partners). Mapping of training will capture relating framework, such as 117 aftercare. Innovative approaches to be considered and agreed (for CHC and Broadcare training) include multi-choice quizzes at the end of training modules, training videos, online feedback, Webinars, BetsiNet Newsfeed; continue to work with ESR to further develop accessible electronic CHC training modules; Improved data collection through group discussions, training needs assessment questionnaires/rolling review of feedback forms and surveys, skills and knowledge analysis, observations from lessons learned; Review | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 210 | Internal Audit | Follow up - Audit Wales: Continuing Healthcare Arrangements Repor | 2022 | Reasonable | High   | Matter Arising 2: CHC service delivery (Operation)                       | 2.1a Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered. | <p>The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development.</p> <p>Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical &amp; Enabling Services &amp; Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31/03/2023 | 30/06/2024 | 2 |  |            | Pending | The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development. Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical & Enabling Services & Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group.                                                                                                                                                                                               | Exec to review |                                                                |
| 211 | Internal Audit | Follow up - Audit Wales: Continuing Healthcare Arrangements Repor | 2022 | Reasonable | High   | Matter Arising 3: Governance, accountability and performance (Operation) | 3.1a The Health Board review the governance and accountability arrangements for CHC which brings together people, quality, performance and financial information.                                                                                                                                                                                         | <p>Continuation of Contracts and Finance reports to PFIG.</p> <p>Continuation of Quality Assurance Framework update to Regional Commissioning Board and Regional Partnership Board. CHC reporting structures (Quality, Finance, and Performance) will be reviewed and there will be a recommendation made to the Executive team regarding a proposed governance and reporting structure for CHC. This will include a proposal that there is Executive Board agreement regarding the Exec lead for CHC, in line with the new Operating model. It will also help to formalise reporting, ensuring a quarterly report goes to a sub-group of the Board.</p> <p>Terms of Reference for CHC/Care Home Quality &amp; Commissioning Group (SMT) will be reviewed. This will strengthen SMT membership in line with recent changes and establishment of IHCs.</p> <p>Further work will be carried out to align the IHC and corporate risk registers.</p> <p>The updated corporate risk register will then be issued for Executive sign-off.</p> <p>The CHC Operations Group TOR will be reviewed to ensure there is a strategic focus, as operational items are included in the Case Management Group remit</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/03/2023 | 30/09/2023 | 1 |  | 28/11/2023 | Pending | Continuation of Contracts and Finance reports to PFIG. Continuation of Quality Assurance Framework update to Regional Commissioning Board and Regional Partnership Board. CHC reporting structures (Quality, Finance, and Performance) will be reviewed and there will be a recommendation made to the Executive team regarding a proposed governance and reporting structure for CHC. This will include a proposal that there is Executive Board agreement regarding the Exec lead for CHC, in line with the new Operating model. It will also help to formalise reporting, ensuring a quarterly report goes to a sub-group of the Board. Terms of Reference for CHC/Care Home Quality & Commissioning Group (SMT) will be reviewed. This will strengthen SMT membership in line with recent changes and establishment of IHCs. Further work will be carried out to align the IHC and                                            | Exec to review |                                                                |



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| 216 | Internal Audit | Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved | 2023 | Limited    | Medium | Matter Arising 4: Governance Frameworks and Communication Strategies (Operation) | 4.1: Governance frameworks, Communication Strategies, and supporting documents should be periodically reviewed and approved to ensure continued relevance and alignment with wider Health Board strategies. Evidence of scrutiny and approval should be retained.  | 4.1: Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality and Safety Group. Please refer to UPCC Peer review Action Plan – IA1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 31/05/2023 | 31/03/2024 | 1 |  |            | Pending | Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality & Safety Group. Please refer to UPCC Peer review Action Plan – IA1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Exec to review |  |
| 217 | Internal Audit | Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved | 2023 | Limited    | High   | Matter Arising 1: UPCC models (Design)                                           | 1.1: The Health Board should consider the future model of the UPCCs to ensure appropriate resources and accommodation are available to provide a consistent service that is accessible to all patients.                                                            | 1.1: Future model for Urgent Primary Care being developed currently, led by the Director of Primary and Community Care and Deputy Executive Medical Director for Primary Care. The future model will be established as part of this work. Please refer to UPCC Peer Review Action Plan – IA3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01/01/2024 | 31/03/2025 | 1 |  |            | Pending | Future model for Urgent Primary Care being developed currently, led by the Director of Primary & Community Care and Deputy Executive Medical Director for Primary Care. The future model will be established as part of this work. Please refer to UPCC Peer Review Action Plan – IA3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Exec to review |  |
| 218 | Internal Audit | Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved | 2023 | Limited    | High   | Matter Arising 2: Benefits realisation (Design)                                  | 2.1: Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2: The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated. | 2.1: Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2: Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01/01/2024 |            | 0 |  |            | Pending | 2.1 Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2 Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases .                                                                                                                                                                                                                                                                                                                                                                                                            | Exec to review |  |
| 219 | Internal Audit | Public Health - Smoke free sites                                                | 2023 | Reasonable | High   | Policy not up to date                                                            | Smoke free policy WP31 is progressed and agreed through the appropriate process as a matter of urgency to become compliant with legislation                                                                                                                        | Receive confirmation from the Board regarding position of smoking shelters across BCUHB in relation to legislation. Feedback to the WOD policy group on acknowledgment of their concerns and our position in line with legislation/ board decision and sign off. Once approved, submit policy to relevant approval groups for ratification. Once ratified, develop communications plan to promote revised policy across the organisation and add to BetsiNet policy pages. On-going review of management plan to ensure policy has been implemented. Review policy for any amendments regarding enforcement/compliance that develop throughout the year. Ensure BCUHB Smoke free Policy links with further policy development across each of the 3 acute hospital sites to support compliance with smoke-free legislation (including due diligence and reasonable steps). To include working with IHC's and Hospital Leads on developing, implementing and monitoring smoke-free hospital plans that support the wider BCUHB smoke free policy. | 31/10/2023 |            | 0 |  | 27/10/2023 | Pending | Receive confirmation from the Board regarding position of smoking shelters across BCUHB in relation to legislation. Feedback to the WOD policy group on acknowledgment of their concerns and our position in line with legislation / board decision and sign off. Once approved, submit policy to relevant approval groups for ratification. Once ratified, develop communications plan to promote revised policy across the organisation and add to BetsiNet policy pages. On-going review of management plan to ensure policy has been implemented. Review policy for any amendments regarding enforcement / compliance that develop throughout the year. Ensure BCUHB Smoke free Policy links with further policy development across each of the 3 acute hospital sites to support compliance with smoke-free legislation (including due diligence and reasonable steps). To include working with IHC's and | Exec to review |  |

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| 220 | Internal Audit | Public Health - Smoke free sites | 2023 | Reasonable   | Medium | MHLDS Training                                                                 | MHLDS Division needs to establish how many staff require VBA training. Clarification is necessary on what training is required with regards to talking about the various NRT options to patients. Conformation by the MHLDS Division that if the contraindications/medical interaction training is not taking place, what is the requirement to meet objective 15. "Admitting practitioners and other relevant staff are aware of contraindications/interactions of using certain types of NRT". All the above must be reflected in the action plan.                                                      | Establish a NRT Training Task and Finish Group to explore and update the 'Guidebook' guidance and recommendation for who needs to complete Level 1 and Level 2 training in MHLD Division. This will determine how many staff are required to complete the training. Recommendation from Task and Finish Group to be received by the MHLD Division Training and Development Group for ratification and recommendation to Operational Leadership Meeting. The Task and Finish Group to consider training required for NRT options to patients. To include mechanism for recording training data to enable monitor and review. The Task and Finish Group will consider how best to address training, if this is required on contraindications/medical interactions training or if this recommendation is best addressed via completion of audit or distribution of information to raise awareness in the prescribing of NRT. The outcome from 2.1a, 2.1b, 2.1c will lead to development of an training plan for rollout across the Division. Completion of audit to assess awareness of NRT options for patients. Present outcome of audit to OLM to agree recommendations to ensure adherence with policy guidance. | 31/01/2024 | 31/03/2024 | 1 |  |  | Pending | Establish a NRT Training Task & Finish Group to explore and update the 'Guidebook' guidance and recommendation for who needs to complete Level 1 and Level 2 training in MHLD Division. This will determine how many staff are required to complete the training. Recommendation from Task and Finish Group to be received by the MHLD Division Training & Development Group for ratification and recommendation to Operational Leadership Meeting. The Task & Finish Group to consider training required for NRT options to patients. To include mechanism for recording training data to enable monitor and review. The Task & Finish Group will consider how best to address training, if this is required on contraindications / medical interactions training or if this recommendation is best addressed via completion of | Exec to review | Wouldn't look at this as reasonable report and medium priority |
| 522 | Internal Audit | Delivery of Health Board Savings | 2023 | No assurance | High   | Matter Arising 2: Voluntary Early Release (VERS) recurring savings (Operation) | 2.1a The Executive Director of Finance ensures all approved VERS applications are acted on in accordance with the requirements of the Remuneration and Terms of Service Committee, with budget and establishment adjusted accordingly.                                                                                                                                                                                                                                                                                                                                                                    | 2.1a: Agreed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 31/03/2024 |            |   |  |  | Pending | VERS budget virements actioned in month 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Close          | superseded by follow up review                                 |
| 602 | Internal Audit | On-Call arrangements             | 2022 | Limited      | High   | Matter Arising 1 – Review of on-call arrangements (Design)                     | 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. | 1.1b: Proposals will be presented to the Executive Team, for approval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 12/10/2022 |            |   |  |  | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review |                                                                |
| 603 | Internal Audit | On-Call arrangements             | 2022 | Limited      | High   | Matter Arising 4 – Training (Design)                                           | 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.                                                                                            | 4.1b: Manual to be developed with key information, and details for those on call.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24/10/2022 |            |   |  |  | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review |                                                                |
| 604 | Internal Audit | On-Call arrangements             | 2022 | Limited      | High   | Matter Arising 4 – Training (Design)                                           | 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.                                                                                            | 4.1c: All staff to receive training with a programme and timescale set for refresher training every two years.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 12/12/2022 |            |   |  |  | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review |                                                                |
| 605 | Internal Audit | On-Call arrangements             | 2022 | Limited      | High   | Matter Arising 4 – Training (Design)                                           | 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.                                                                                            | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10/09/2022 |            |   |  |  | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exec to review |                                                                |

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| 1230 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHLDD have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.2: Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams          |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1231 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHLDD have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.3a: Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service                                                                                      |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1232 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHLDD have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.3b: Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |

|      |                |                                                |      |            |      |                                                                                                              |                                                                                                                                                                                                            |                                                                                                                                                                                                      |  |  |  |  |  |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |  |
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| 1233 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.4: Divisional Accountability meetings with each area to be stood up to support the additional scrutiny and interventions required to vacancy position, recruitment processes and accuracy of data. |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1234 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.5: Provide ongoing progress of the Just R Marketing campaign within the MH&LD Staff Briefing.                                                                                                      |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1235 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.6: Discussion of monthly Divisional Vacancy and Recruitment report at MH&LD Service People and Culture Delivery Group meeting.                                                                     |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |

|      |                |                                                |      |            |      |                                                                                                              |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |  |
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| 1236 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.7: On-going progress with Just R Marketing campaign, talent pool process and further development of innovative approaches to address the number of vacancies across the Division                                                                                                                         |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1237 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.8: Creation of Quarterly report which will be presented at Operational Leadership Meeting (OLM) feeding into MH&LD Senior Leadership Team meeting to show impact and outcomes of the Just R Marketing campaign, to discuss and agree any further plans to address current vacancies across the Division. |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |
| 1238 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.9: Ongoing progress and delivery of actions included in the Wellness, Work and Us Year 3 plan aligned to staff recruitment and retention, with creation of 36 month report to show impact, outcomes and recommendations aligned to addressing staff recruitment and retention                            |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |  |

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| 1239 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.10: Continued monitor and review of Workforce work stream programme plan, recording and reporting impacts and outcomes of delivery.                                                          |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and agreed. | Exec to review |  |
| 1240 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.11: Development of a MH&LD Recruitment and Retention Strategy to ensure short, medium and long term focus on workforce recruitment and retention across all staff group within the Division. |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and agreed. | Exec to review |  |
| 1241 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management. | 4.12: Review of all interim posts across the Division                                                                                                                                          |  |  |  |  |  | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and agreed. | Exec to review |  |



|      |                |                                                |      |            |        |                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |            |            |   |            |            |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                                                |
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| 1242 | Internal Audit | Mental Health & Learning Disabilities Division | 2023 | Reasonable | High   | Matter Arising 4: Issues identified relating to the workforce within MHL D have been progressed, (Operation) | 4. Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4.13: Discuss and agree a plan to progress with substantive appointment to posts aligned to the MH&LD Operating Model.                                                                                                                               |            |            |   |            |            | Pending | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and new additional | Exec to review |                                                                |
| 1266 | Internal Audit | Chairs action                                  | 2022 | Reasonable | High   | Matter Arising 1: Process Design (Design)                                                                    | 1.2: The Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally/request made to OBS/authorisation granted by IMs and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted. | 1.2: Chair's Actions will be universally captured as part of the Chair's written report to the Board/Committee with effect from October 2022.                                                                                                        | 31/01/2023 | 29/02/2024 | 1 | 30/09/2023 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review |                                                                |
| 1267 | Internal Audit | Chairs action                                  | 2022 | Reasonable | High   | Matter Arising 1: Process Design (Design)                                                                    | 1.3: The Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally/request made to OBS/authorisation granted by IMs and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted. | 1.3: A review of the Terms of Reference for Board and Committees will be scheduled as part of the COB and Chair's Actions and will include the authority to undertake Chair's actions on behalf of the Board, as set out in the Scheme of Delegation | 31/01/2023 | 29/02/2024 | 1 | 30/09/2023 | 09/02/2024 | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review |                                                                |
| 1268 | Internal Audit | Chairs action                                  | 2022 | Reasonable | Medium | Matter Arising 4: Lessons Learned (Design)                                                                   | 4.2: The Health Board should liaise with Board Secretaries/Office of Board Secretaries from HB3 and HB4, which may highlight areas where lessons can be learned to aid in reducing the number of actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4.2: Discuss at the national Board Secretaries forum what other organisations are doing and understand if there is the appetite for a once for all Wales approach to the Chair's Action Process.                                                     | 31/01/2023 | 29/02/2024 | 1 |            |            | Pending | No update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Exec to review | Wouldn't look at this as reasonable report and medium priority |

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| <b>Teitl adroddiad:</b><br><i>Report title:</i>           | Welsh Health Circulars and Ministerial Directions –<br>update from 1 <sup>st</sup> April 2024 to 31 <sup>st</sup> August 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Adrodd i:</b><br><i>Report to:</i>                     | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>     | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i> | <p>The purpose of this report is to provide the Audit Committee with an:</p> <ul style="list-style-type: none"> <li>• update on the process for receiving and actioning, where necessary Welsh Health Circulars (WHCs) within the Health Board</li> <li>• update on the process for receiving and actioning, where necessary Ministerial Directions (MDs) within the Health Board</li> <li>• update on the current position regarding WHCs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024</li> <li>• update on the current position regarding MDs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024</li> <li>• update on reporting cycle regarding WHCs and MDs to Executive Team and Audit Committee.</li> </ul> |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Argymhellion:</b><br><i>Recommendations:</i>           | <p>The Audit Committee is asked to:</p> <ul style="list-style-type: none"> <li>• <b>APPROVE</b> the process for receiving Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) in the Health Board, and ensuring these are actioned as necessary</li> <li>• <b>APPROVE</b> the reporting cycle on WHCs and MDs to the Audit Committee</li> <li>• <b>NOTE</b> the current position regarding WHCs and MHDs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024.</li> </ul>                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Arweinydd Gweithredol:</b><br><i>Executive Lead:</i>   | Pam Wenger, Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Awdur yr Adroddiad:</b><br><i>Report Author:</i>       | Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>  | <p>I'w Nodi<br/><i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>I Benderfynu arno<br/><i>For Decision</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                                   | <p>Am sicrwydd<br/><i>For Assurance</i></p> <p><input type="checkbox"/></p>                                                                                                                                                                        |                                                                                                                                                                                  |
| <b>Lefel sicrwydd:</b><br><i>Assurance level:</i>         | <p>Arwyddocaol<br/><i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>Derbyniol<br/><i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Rhannol<br/><i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Dim Sicrwydd<br/><i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p> |

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| <p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><i>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: N/A</i></p> |                                                                                                                                                                                                                                                                 |
| <p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><i>Link to Strategic Objective(s):</i></p>                                                                                                                                                                                                                                                                                                                                                        | <p>Building an Effective Organisation</p>                                                                                                                                                                                                                       |
| <p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><i>Regulatory and legal implications:</i></p>                                                                                                                                                                                                                                                                                                                                                         | <p>It is essential that the Health Board has robust arrangements in place to assess, capture and provide assurance on actions taken to comply with Welsh Health Circulars (WHCs) and Ministerial Directions (MDs).</p>                                          |
| <p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>                                                                                                                                                                                                                                                                          | <p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups</p>          |
| <p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has a SEIA identified as necessary been undertaken?</i></p>                                                                                                                                                                                                                                                                            | <p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.</p> |
| <p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>                                                                                                                                                             | <p>Not applicable, other than those relating to the information contained within the WHCs and MDs</p>                                                                                                                                                           |
| <p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>                                                                                                                                                                                                                                                                                       | <p>Not applicable, other than the financial implementations of the WHCs and MDs</p>                                                                                                                                                                             |
| <p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>                                                                                                                                                                                                                                                                                       | <p>Failure to capture, assess and implement WHC and MD can have an adverse impact on the workforce.</p>                                                                                                                                                         |
| <p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>                                                                                                                                                                                                                                                                                                       | <p>Not applicable for this report.</p>                                                                                                                                                                                                                          |
| <p><b>Cysylltiadau â risgiau BAF:</b><br/>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i><br/>(or links to the Corporate Risk Register)</p>                                                                                                                                                                                                                                                                        | <p>Strategic Objective - Failure to Build an Effective Organisation</p> <p>CRR 24 – 16 Leadership - is the key Corporate Risk related to this work.</p>                                                                                                         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| <p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><i><b>Reason for submission of report to confidential board (where relevant)</b></i></p>                                                                                                                                                                                                                                                   | <p>Not applicable</p> |
| <p><b>Camau Nesaf:</b></p> <p><i><b>Next Steps:</b></i></p> <ol style="list-style-type: none"> <li>1. Ongoing implementation of the process to source and record newly-published WHCs and MDs, and circulation for update to the relevant Executive Director</li> <li>2. Quarterly update report to the Executive Team on WHCs and MDs</li> <li>3. Six-monthly report to Audit Committee on newly-published WHCs and MDs.</li> </ol> |                       |
| <p><b>Rhestr o Atodiadau:</b></p> <p><i><b>List of Appendices:</b></i></p> <p>Appendix 1 – List of Welsh Health Circulars received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024</p> <p>Appendix 2 – List of Ministerial Directions received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024</p>                                                                                                       |                       |

# **WELSH HEALTH CIRCULARS AND MINISTERIAL DIRECTIONS – 1<sup>st</sup> APRIL 2024 TO 31<sup>st</sup> AUGUST 2024**

## **1. INTRODUCTION**

The purpose of this report is to provide an update on the processes in place for receiving and actioning Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) in the Health Board, as well as and to give a summary update on those received and actioned between 1<sup>st</sup> April 2024 and 31<sup>st</sup> August 2024.

In addition to this, the report provides information in relation to the reporting cycle for these documents, to both the Executive Team and Audit Committee.

## **2. BACKGROUND**

WHCs and MDs contain important information that the Health Board need to review and enact if required. The 2023 'Office of the Board Secretary Review' contained a recommendation to *'Review the management of WHCs and MDs to ensure these are tracked through Committees in terms of the compliance achieved against each for onward assurance to the Board'*.

The Corporate Governance Directorate has responsibility for maintaining a library of all WHCs and MDs received, the name of the identified Executive Director lead, and to capture actions being undertaken to ensure implementation and compliance.

It is proposed to report on a quarterly basis to the Executive Team, and a twice yearly to the Audit Committee.

## **3. OUTLINE OF PROCESS**

### **3.1 Welsh Health Circulars**

The Corporate Governance Directorate have an established process in place to collect newly published WHCs by Welsh Government, and to receive updates from within the Health Board on progress for their implementation. These WHCs are received automatically via e-mail from Welsh Government when published, and a regular list is also provided by Welsh Government for cross-reference. Also, in order to reinforce this process, and to ensure that the Health Board does receive all notification of newly-published WHCs, the Corporate Governance Directorate conducts a weekly manual search of the Welsh Government website.

When the Health Board becomes aware of newly-published WHCs, these documents are logged on the Corporate Governance Directorate Legislation Library, and copies of the relevant documentation circulated to the Executive Director lead, with a request for an update on progress and actions required to implement or enact, if relevant.

## **3.2 Ministerial Directions**

The process for capturing MDs is in its infancy, and discussions are ongoing with Welsh Government to see if newly-published MDs can be submitted directly to the Health Board, as is the case with WHCs. In the absence of this process, and to ensure that the Health Board is aware of all newly-published MDs, the Corporate Governance Directorate conducts a weekly manual search of the Welsh Government publications website to identify any new MDs.

Once received, these documents are logged on the Corporate Governance Directorate Legislation Library, and circulated to the Executive Director lead, with a request for an update on progress and actions required to implement or enact, if relevant.

## **4. CURRENT POSITION**

### **4.1 Welsh Health Circulars**

A total of 22 WHCs have been received between 1<sup>st</sup> April 2024 and 31<sup>st</sup> August 2024. All these have been shared with the relevant Executive lead, and updates on progress received.

A copy of the Legislation Library containing the WHCs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024, together with a summary status update as at 22<sup>nd</sup> October 2024 is included in Appendix 1.

### **4.2 Ministerial Directions**

A total of 12 MDs have been received between 1<sup>st</sup> April 2024 and 31<sup>st</sup> August 2024. All these have been shared with the relevant Executive lead, and updates on progress received.

A copy of the Legislation Library containing the MDs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024, together with a summary status update as at 22<sup>nd</sup> October 2024 is included in Appendix 2.

## **5. REPORTING**

A report on the current position with the WCDs and MDs received by the Health Board, as well as updates on their progress will be submitted to the Executive Team on a quarterly basis, and a twice-annually to the Audit Committee.

The first update on WHCs and MDs to the Executive Team was on 9<sup>th</sup> October 2024, with the next update in January 2025, and this will include WHCs and MDs from 1<sup>st</sup> September 2024 to 31<sup>st</sup> December 2024 (September plus quarter 3), bringing the quarterly reporting updates in line.

A report on WHCs and MDs received between 1<sup>st</sup> April 2024 and 31<sup>st</sup> August 2024 will be provided to the Audit Committee on 5<sup>th</sup> November 2024, and the September 2024 to March 2025 updates in the new financial year, again, bringing the twice-yearly reporting in line.



## 6. **RECOMMENDATIONS**

The Audit Committee is asked to:

- **APPROVE** the process for receiving Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) in the Health Board, and ensuring these are actioned as necessary
- **APPROVE** the reporting cycle on WHCs and MDs to the Audit Committee
- **NOTE** the current position regarding WHCs and MHDs received from 1<sup>st</sup> April 2024 to 31<sup>st</sup> August 2024.

## 7. **BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

Resources for progressing the work around the WHCs and MDs lie with the relevant directorate, division, or department as part of business-as-usual functions.

## 8. **RISK MANAGEMENT**

It is essential that the Health Board implements directions received within WHCs and MDs in line with the published implementation dates (where provided) in order to minimise risks associated with those areas of work.

There are risks to the Health Board relating to information contained within the WHCs and MDs as they highlight areas of change or improvement required by the Health Board. Any risks to the Health Board identified from WHCs and MDs should be dealt with in line with our risk management policies and procedures.

## 9. **EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, Equality and Diversity compliance should be fully considered when implementing changes to processes and procedures in line with the requirements of the WHCs and MDs.

**APPENDIX 1 – LIST OF WELSH HEALTH CIRCULARS RECEIVED FROM 1ST APRIL  
2024 TO 31ST AUGUST 2024**

**APPENDIX 2 – LIST OF MINISTERIAL DIRECTIONS RECEIVED FROM 1ST APRIL  
2024 TO 31ST AUGUST 2024**

**APPENDIX 1 - WELSH HEALTH CIRCULARS 2024 LIBRARY**

Information as at 22/10/2024

|    | WHC ID       | Publication date | Welsh Health Circular Title                                                                                                     | Link to WHC                                                                                                  | Description                                                                                                                                                                                                                                                         | Executive Lead                                                                                          | Lead Officer                                    | Action Required by BCUHB (Compliance / Action / For Information) | Date Action Required By (if known)                | Details of Action Taken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | All action completed Yes/No/Partial |
|----|--------------|------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1  | WHC/2024/007 | 15/08/2024       | Guidelines for managing patients on the suspected cancer pathway                                                                | <a href="#">Guidelines for managing patients on the suspected cancer pathway (WHC/2024/007)</a>              | Guidelines for managing patients on suspected cancer pathway and how to report against targets                                                                                                                                                                      | Nick Lyons, Executive Medical Director                                                                  | James Risley, Deputy Executive Medical Director | All                                                              | Immediate                                         | <b>19/08/2024</b> Caroline Williams advised 'these guidelines were originally issued by Welsh Govt in April 2024 (the document is dated 10 <sup>th</sup> April 2024) and so I don't know why they have been reissued. We incorporated them into our local 'Guide to SCP rules and tracking' document for cancer services staff in May and have been using them ever since. No further action required – fully compliant'.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes                                 |
| 2  | WHC/2024/013 | 10/04/2024       | Governance on interim appointments to executive and senior positions                                                            | <a href="#">Governance on interim appointments to executive and senior positions (WHC/2024/013)</a>          | How NHS Wales organisations can meet the recruitment principles for interim appointments.                                                                                                                                                                           | Jason Brannan, Deputy Director of People                                                                |                                                 | Compliance                                                       | Immediate                                         | <b>23/05/2024.</b> Gill Querri confirmed that the WHC was received by the Remuneration Committee on 11th June, extract from the minutes as follows:<br>R24/43 WHC2024/013 – Governance in Recruitment<br>R24/43.1 The report was received. It was noted that this Welsh Health Circular was applicable only to Executive level appointments.<br>Resolved: it was agreed that the report be noted.<br>NO FURTHER ACTION REQUIRED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Yes                                 |
| 3  | WHC/2024/014 | 15/08/2024       | Introducing ONS geographic codes for use as standard in NHS Wales                                                               | <a href="#">Introducing ONS geographic codes for use as standard in NHS Wales (WHC/2024/014)</a>             | We are mandating the Office for National Statistics' (ONS's) codes for geographic data in all NHS Wales IT and digital systems or services.                                                                                                                         | Dylan Roberts, Chief Digital and Information Officer                                                    |                                                 | Action                                                           | Immediate                                         | <b>09/10/2024</b> – following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Dylan Roberts and Sophie Thomas, deadline 16/10/2024.<br><b>16/10/2024</b> – update received from Kathryn Lang - This WHC relates to the use of codes to identify location types. These are managed through national reference tables for application to datasets for analysis, outside of the data collection systems, for example identifying local authority ward based on postcode data collected in a BCU system. It is my understanding that there is no action for us to take on this, we will work to the national reference tables as provided. I've spoken with the head of Data Standards for NHS Wales and am awaiting confirmation from the Welsh Reference Data Service Manager. <i>Awaiting final confirmation that no action required, as is believed to be the case.</i> | Partial                             |
| 4  | WHC/2024/016 | 11/04/2024       | Healthy Child Wales Programme: for school aged children                                                                         | <a href="#">Healthy Child Wales Programme: for school aged children (WHC/2024/016)</a>                       | A new operating model for school nursing services in NHS Wales                                                                                                                                                                                                      | Jane Moore, Acting Executive Director of Public Health                                                  |                                                 | Action / Information                                             | 01/04/2026                                        | <b>17/06/2024</b> Update received from Jane Moore/Sarah Andrews - WHC (2024) 016 was issued in April and Health Boards are expected to address and complete implementation over a two year period.<br>At this stage actions to be reported as completed will be known about and reported within oversight and governance of children's services, however our public health reporting structure will need to recognise and flag progress as with other WHCs and directives, especially the public health badged content including needs assessments.                                                                                                                                                                                                                                                                                                                                                                    | Partial                             |
| 5  | WHC/2024/017 | 05/04/2024       | Implementation of the non-pay parts of the 2022 to 2024 collective agreement                                                    | <a href="#">Implementation of the non-pay parts of the 2022 to 2024 collective agreement (WHC/2024/017)</a>  | Letter to NHS Wales organisations about effecting the non-pay parts of the 2022 to 2024 collective agreement.                                                                                                                                                       | Russell Caldicott, Interim Executive Director of Finance                                                |                                                 | Action                                                           | N/A                                               | <b>29/05/2024</b> Russell Caldicott confirmed that Workforce are taking this forward and have presented through George to Executive.<br><b>31/05/2024</b> Jason Brannan emailed Judith Paget, Inc Assurance report<br>NO FURTHER ACTION REQUIRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Yes                                 |
| 6  | WHC/2024/019 | 17/04/2024       | Changes to standing orders in health boards and NHS trusts                                                                      | <a href="#">Changes to standing orders in health boards and NHS trusts (WHC/2024/019)</a>                    | There are updates to standing orders after the start of the NHS Wales Joint Commissioning Committee, and the end of two health committees.                                                                                                                          | Pam Wenger, Director of Corporate Governance                                                            |                                                 | Compliance                                                       | In accordance with Board and committees timetable | HB23/258 Review of Health Board Standing Financial Instructions<br><br>It was resolved that the Board<br>•Approved the incorporation and adoption of the Standing Financial Instructions as Schedule 2.1 of the Standing Orders.<br>•Approved the incorporation and adoption of the Standing Orders for WHSSC and EASC as Schedules 4.1 and 4.2 of the Health Board's own Standing Orders.<br>NO FURTHER ACTION REQUIRED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes                                 |
| 7  | WHC/2024/020 | 15/08/2024       | New treatment fund: directions on the exemptions for health boards and trusts                                                   | <a href="#">New treatment fund: directions on the exemptions for health boards and trusts (WHC/2024/020)</a> | What local health boards and NHS trusts must do to make medicines and other interventions available.                                                                                                                                                                | Nick Lyons, Executive Medical Director; Teresa Owen, Executive Director of Therapies and Health Science | James Risley, Lois Lloyd                        | Compliance / Action                                              | Immediate. (01/05/24)                             | <b>15/08/24</b> Update from Lois Lloyd - to be put on next DTG agenda. Asked Teena Grenier for any recommendations and advised Andrea Hughes of new direction.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Partial                             |
| 8  | WHC/2024/022 | 25/04/2024       | Dispute Arbitration Process - Guidance for Disputed Debts (invoices and service agreements) within NHS Wales: 2024/25 – 2026/27 |                             | This procedure will apply to all NHS Trusts, Local Health Boards and Special Health Authorities in Wales. In addition, this process and procedure will equally apply to the Joint Commissioning Committee (JCC), and NHS Wales Shared Services Partnership (NWSSP). | Russell Caldicott, Interim Executive Director of Finance                                                |                                                 | Compliance                                                       | 01/04/2027                                        | <b>17/06/2024</b> Advised by Russell Caldicott that this WHC has been shared with all relevant colleagues.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Partial                             |
| 9  | WHC/2024/024 | 17/05/2024       | Implementation the agreed approach to preventing Violence and Aggression towards NHS staff in Wales                             | <a href="#">Anti-violence collaborative, obligatory responses document (WHC/2024/024)</a>                    | An agreed approach to preventing violence and aggression towards NHS staff in Wales                                                                                                                                                                                 | Jason Brannan, Deputy Director of People                                                                |                                                 | Action                                                           | Immediately                                       | <b>24/06/2024</b> Gill Querri confirmed that a response has been drafted, which is with Jason B for review/approval.<br><b>05/09/2024</b> Gill Querri confirmed that actions outlined within this WHC are being progressed by the appropriate colleagues within the Health & Safety Team. <b>Going forward, the lead Executive will move to the Director of Environment &amp; Estates, once in post.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Partial                             |
| 10 | WHC/2024/025 | 04/06/2024       | NHS Wales national clinical audit and outcome review plan 2024 to 2025                                                          | <a href="#">NHS Wales national clinical audit and outcome review plan 2024 to 2025 (WHC/025/24)</a>          | How we will measure the quality and safety of healthcare services as part of an annual rolling programme                                                                                                                                                            | Nick Lyons, Executive Medical Director                                                                  | Karen Higgins                                   | For information                                                  | N/A                                               | <b>17/06/2024</b> James Risley confirmed that this has gone through SCEG (Strategic Clinical Effectiveness Group) and therefore no further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Yes                                 |
| 11 | WHC/2024/026 | 22/05/2024       | NHS Wales financial monitoring guidance 2024 to 2025                                                                            | <a href="#">NHS Wales financial monitoring guidance 2024 to 2025 (WHC/2024/026)</a>                          | Guidance for health boards, special health authorities and trusts on monthly financial returns                                                                                                                                                                      | Russell Caldicott, Interim Executive Director of Finance                                                |                                                 | Compliance                                                       | 01/04/2025                                        | <b>28/05/2024</b> Michelle Jones, Head of Financial Reporting, confirmed that they will be making the necessary returns on a monthly basis. No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes                                 |
| 12 | WHC/2024/027 | 19/06/2024       | Critical care escalation guidance                                                                                               | <a href="#">Critical care escalation guidance (WHC/2024/027)</a>                                             | Updated guidance for health boards in Wales on how to deal with large increases in demand for critical care                                                                                                                                                         | Nick Lyons, Executive Medical Director                                                                  | James Risley, Deputy Executive Medical Director | Information                                                      | Immediate                                         | <b>19/06/2024</b> James Risley confirmed that no action necessary as already covered in existing planning.<br>NO FURTHER ACTION REQUIRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Yes                                 |

|    |               |            |                                                                                  |                                                                                                                 |                                                                                                                                                                                      |                                                                                                                            |                                                                                    |                     |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |
|----|---------------|------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| 13 | WHC/2024/028  | 12/06/2024 | The national influenza immunisation programme 2024 to 2025                       | <a href="#">The national influenza immunisation programme 2024 to 2025 (WHC/2024/028)</a>                       | Letter to health professionals about the national influenza immunisation programme 2024 to 2025.                                                                                     | Jane Moore, Acting Executive Director of Public Health                                                                     |                                                                                    | Compliance / Action | N/A         | <b>30/07/2024</b> Katie Spruce confirmed that slide deck was sent 26/07/24. Draft Winter Respiratory plans have been submitted to VPW and final plans are due for submission 9th August, we are still firming these up with our primary care providers.<br><b>15/08/2024</b> Katie Spruce advised 'Plans were submitted in final on 09/08/24, however since had feedback and amendments to make. Will forward once complete and submitted'.<br><b>23/09/2024</b> All comms, and promotional materials have been cascaded accordingly to primary care. Betsinet is up to date with booking information. Adult programme commences 30/09/24 for all providers. LAIV for 2-3 year olds commenced 09/09/24 and is well underway. All school age programmes have plans in place and vaccination has started Wc 16/09/24.<br>Pregnant ladies commenced vaccination from 04/09/24. All PGDs have been cascaded to primary care partners and available on Betsinet. Flu plans have been received from Primary Care and collated into a capacity plan for monitoring and governance. Flu fortnightly meetings are established and haven in planning and support mode from 1/08/24 and will move into programme mode following commencement on 30/09/24. Well represented from many areas of the Health board. Action/Decision/ Risk logs all in place and full governance and measuring. Reporting into the NHS Executive along with all other immunisations from 01/10/24. Vaccine orders have been received into primary care. Occupational health have approx. 356 local vaccinators identified to assist. Health Protection Team and Vaccination & Immunisation teams to deliver flu with an offer of Covid-19, allowing co-administration for staff this winter. All training modules are live for staff to undertake and further materials have been circulated to assist. | Yes     |
| 14 | WHC/2024/029  | 11/06/2024 | Certification of vision impairment in primary and community care                 | <a href="#">Certification of vision impairment in primary and community care (WHC/2024/029)</a>                 | How changes to the certification form affects the process for certifying patients as partially sighted or blind                                                                      |                                                                                                                            | Karen Higgins??                                                                    | Compliance          | Immediately | <b>17/06/2024</b> Advised that Karen Higgins is no longer Primary Care, so forwarded to Ffion Johnstone & Chris Stockport, cc Sandra<br><b>18/06/2024</b> Ffion advised that there is no action to be taken and that it is for information, describing the changes in process.<br>NO FURTHER ACTION REQUIRED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Yes     |
| 15 | WHC/2024/031  | 14/06/2024 | Agency workforce reduction programme and control framework 2024 to 2025          | <a href="#">Agency workforce reduction programme and control framework 2024 to 2025 (WHC/2024/031)</a>          | Circular to NHS Wales organisations about taking a phased approach to reducing agency spend in NHS Wales.                                                                            | Jason Brannan, Deputy Director of People; Russell Caldicott, Interim Executive Director of Finance                         |                                                                                    | Action              | N/A         | <b>29/07/2024, 19/08/2024 and 23/09/2024</b> updates requested.<br><b>09/10/2024</b> - following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Jason Brannan, Gill Querci, Steven Gregg-Rowbury, Susan Dallimore and Natalie Morris-Evans - deadline 16/10/2024. Await response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No      |
| 16 | WHC/2024/032  | 24/06/2024 | Introduction of RSV vaccination programme 2024                                   | <a href="#">Introduction of RSV vaccination programme 2024 (WHC/2024/032)</a>                                   | Letter to health professionals about the new Respiratory Syncytial Virus (RSV) vaccination campaign                                                                                  | Jane Moore, Acting Executive Director of Public Health                                                                     |                                                                                    | Action              | N/A         | <b>29/07/2024</b> - Received 2 x RSV (Respiratory Syncytial Virus) plans which have been submitted to VPW (Vaccination Programme Wales) outlining approach in depth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yes     |
| 17 | WHC/2024/033  | 02/08/2024 | Winter respiratory vaccination programme 2024 to 2025                            | <a href="#">Winter respiratory vaccination programme 2024 to 2025 (WHC/2024/033)</a>                            | Details of the next winter vaccination programme for coronavirus (COVID-19) and influenza                                                                                            | Jane Moore, Acting Executive Director of Public Health                                                                     |                                                                                    | Compliance/Action   | N/A         | <b>19/08/2024</b> Katie Spruce confirmed that this has been actioned on 09/08/24 and amendments were submitted 16/08/24. Nothing further received from National as yet.<br><b>22/08/2024</b> Sam Lauder confirmed 'The Health Protection Service acknowledge the above mentioned WHC and have offered support to the winter respiratory programme particularly in relation to the uptake of flu vaccinations in our own Health Board staff. The Health Protection Service will be working with the Health at Work team to provide access to flu vaccinations at each of the 3 DGH sites and also some support at community site also. Where additional vaccinators are required, the Health Protection Service will remain willing to support where capacity allows. '                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Yes     |
| 18 | WHC/2024/0234 | 28/08/2024 | National framework for commissioning care and support                            | <a href="#">National framework for commissioning care and support (WHC/2024/0234)</a>                           | Directions to local health boards and NHS trusts to comply with the national framework                                                                                               | Chris Stockport; Teresa Owen; Imran Devji; Russell Caldicott                                                               | Jane Trowman, Acting Assistant Director – Care Homes Support and CHC Commissioning | Compliance          | 01/09/2024  | <b>02/09/2024</b> Jane Trowman confirmed that they are fully aware of the WHC and its implication for CHC.<br><b>24/09/2024</b> JT confirmed that BCU has been advised that this framework will now NOT be implemented until at least February 25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Partial |
| 19 | WHC/2024/035  | 18/09/2024 | Standardising the management of acute deterioration                              | <a href="#">Standardising the management of acute deterioration (WHC/2024/035)</a>                              | A national approach for identifying when care should increase if a patient's condition worsens                                                                                       | Angela Wood, Executive Director of Nursing and Midwifery                                                                   |                                                                                    | Action              | N/A         | <b>18/09/2024</b> - Angela Wood confirmed that WHC had been forwarded to the Exec Medical Director deputies andnd Marie to cascade. AW also confirmed that it was being sent to the Senior Nurses to cascade to their teams.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Partial |
| 20 | WHC/2024/036  | 29/08/2024 | Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder    | <a href="#">Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036)</a>    | Directions to local health boards and NHS trusts following a regulation 28 prevention of future deaths report and oxygen cylinders patient safety notice (PSN) about oxygen cylinder | Angela Wood, Executive Director of Nursing and Midwifery                                                                   |                                                                                    | Action              | 30/09/2024  | <b>29/08/2024</b> Chris Lynes confirmed that this WHC had been received by Andrew Merriman, chair of the Medical Gases Group, who will action the alert through that group and feed up to the patient safety group .<br><b>30/08/2024</b> Angela confirmed that she will be lead exec for this.<br><b>30/08/2024</b> Andrew Merriman, interim chair of Medical Gases Group (MGG), stated that any actions or escalations noted at the MGG, including action owners can be shared within the appropriate governance as well as at PSG.<br><b>11/09/2024</b> AM confirmed that this was on the agenda for the Medical Gas Group (MGG) to discuss on 12/09/2024.<br><b>23/09/2024</b> Update received from AM. WHC was discussed at the MGG. The patient safety team are chelating all of the information across the HB and will use this information to populate and submit the compliance return response. Any outstanding actions will be managed through the medical gas group as a standing agenda item.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Partial |
| 21 | WHC/2024/037  | 24/09/2024 | Winter respiratory framework 2024 to 2025                                        | <a href="#">Winter respiratory framework 2024 to 2025 (WHC/2024/037)</a>                                        | Our plans for the NHS, social care and communities for managing respiratory viruses.                                                                                                 | Imran Devji, Interim Chief Operating Officer                                                                               |                                                                                    | Action              |             | <b>24/09/2024</b> Cascaded by the Medical Directorate. FL awaiting response from Imran Devji as to who should be the Exec lead.<br><b>25/09/2024</b> Chased Imran for answer.<br><b>09/10/2024</b> following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Imran Devji and Sandra Ingham - deadline 16/10/2024.<br><b>17/10/2024</b> Sandra Ingham confirmed that the information has been circulated to IHC Directors for wider distribution, Sharon Scott will ensure it is referred to in the Winter Plan, due to its reference to Health Protection. Info also sent to Sam Lauder, Public Health, and Jane Trowman for distribution to Care Homes. <b>Awaiting confirmation from IHCs that they have actioned.</b><br><b>17/10/2024</b> Lois Lloyd confirmed the allocations:<br>- Vaccination element lies with me as SRO with Jane Moore as Exec DPH.<br>- Antiviral distribution and community pharmacy access as well with her.<br>- Process:<br>- Vaccination - Strategic Immunisation Group noted actions and delivery oversight via area operational immunisation group.<br>- Antiviral access for care homes operationalised via her office and linked with Sharon as EPRR and oversight by Primary Care Board<br>- Community Pharmacy access via her office aligned to UEC in annual plan.<br>18/10/2024 Received confirmation from West and East IHCs that they actioned the WHC. <b>Awaiting confirmation from Central</b>                                                                                                                                                                                                                                                                                                                                                                              | Partial |
| 22 | WHC/2024/038  | 20/09/2024 | Healthcare associated infections and antimicrobial resistance goals 2024 to 2025 | <a href="#">Healthcare associated infections and antimicrobial resistance goals 2024 to 2025 (WHC/2024/038)</a> | Our expectations for health boards and trusts to reduce care related illness and resistance to antibiotic                                                                            | Angela Wood, Executive Director of Nursing (previously assigned to Jane Moore, Acting Executive Director of Public Health) |                                                                                    | Action/Information  | Immediate   | Update from ET <b>09/10/2024</b> - the lead for this is Angela Wood, not Jane Moore. Information to be circulated to Angela Wood.<br><b>10/10/2024</b> As per note above, details sent to Angela Wood<br><b>11/10/2024</b> Meeting arranged with Mandy Jones/Andrea Ledgerton to discuss<br><b>17/10/2024</b> Angela Wood forwarded request to Andrea Ledgerton asking her to identify what plans are for each goal, for it then to be presented to the next IPG and EQDG.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No      |

## APPENDIX 2 - MINISTERIAL DIRECTIONS LIBRARY

Information as at 22/10/2024

|   | MD ID   | Publication date | Ministerial Direction title                                                                                                                                                                                                                               | Link to Ministerial Direction                                                                                                                                                                                                  | Executive Lead                                                               | Lead Officer                                                       | Action required Yes/No/Unknown at present | Update on action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | All action completed Yes/No/Partial |
|---|---------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1 | WG24-10 | 19/04/2024       | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024                                                                                          | <a href="#">Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024</a>                                                                                            | Russell Caldicott, Interim Executive Director of Finance                     | Andrea Hughes, Interim Director of Finance                         | No                                        | <b>08/10/2024</b> Andrea Hughes confirmed that the GMS payments are made on our behalf of the Health Boards by the Shared Services Partnership and any contract content changes as a result of amended Directions would be actioned once for Wales. CFO Team confirmed that all Primary Care directions relating to fees, payments and Contract change are actioned by Shared Services to ensure consistent application across Wales. No further action for BCU; the NHS Shared Services Partnership will reflect the updated Directions, as applicable, into the all Wales process to ensure consistency for all Health Boards.                                                                                                                                                                                | Yes                                 |
| 2 | WG24-17 | 29/04/2024       | NATIONAL HEALTH SERVICE (WALES) ACT 2006. the directions to Local Health Boards and NHS Trusts in Wales 2003 and the managed introduction of New Medicines into the National Health Services in Wales Directions 2009 (amendment) (Wales) Directions 2024 | <a href="#">The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New Medicines into the National Health Service in Wales Directions 2009 (Amendment) (Wales) Directions 2024</a> | Imran Devji, Interim Chief Operating Officer                                 | Lois Lloyd, Chief Pharmacist                                       | Yes                                       | <b>23/09/2024</b> - Chased, awaiting response from Lois Lloyd.<br><b>09/10/2024</b> - following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Imran Devji, Lois Lloyd and Sandra Ingham, deadline 16/10/2024.<br><b>17/10/2024</b> Lois Lloyd confirmed that The Ministerial Direction allows flexibility around the 60 day implementation target for the New Treatment Fund (NTF) when dates set either by NICE or Welsh Governments (WG). The MD has been received and noted at the Health Board's Drug and Therapeutics Group who endorsed the MD, and the process has been updated accordingly with monthly updates to the Strategic Clinical Effectiveness Group and Executive Team. As such, the MD is noted to be complied with, and fully implemented. | Yes                                 |
| 3 | WG24-20 | 24/06/2024       | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Directed Supplementary Services) (Wales) Directions 2024                                                                                                                       | <a href="#">The Primary Medical Services (Directed Supplementary Services) (Wales) Directions 2024</a>                                                                                                                         | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No                                        | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DEs) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DEs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions.                                                                                                                                                                                          | Yes                                 |

|   |         |            |                                                                                                                                                                                                |                                                                                                                                                                   |                                                                              |                                                                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |
|---|---------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| 4 | WG24-21 | 24/06/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Pertussis Immunisation for Pregnant and Post-natal Women) (Directed Supplementary Services) (Wales) Directions 2024 | <a href="#">The Primary Medical Services (Pertussis Immunisation for Pregnant and Post-Natal Women) (Directed Supplementary Services) (Wales) Directions 2024</a> | Jane Moore, Acting Executive Director of Public Health                       | Fiona Giraud, Director of Midwifery and Womens Services            | Yes | <b>23/09/2024</b> - Re-directed this to Jane Moore / Fiona Giraud - awaiting response.<br><b>09/10/2024</b> - following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Jane Moore, Fiona Giraud and Rhian Baker, deadline 16/10/2024.<br><b>09/10/2024</b> Glesni responded to Rhian, provided details of what required. Await response<br><b>16/10/2024</b> Katie Spruce provided comprehensive update, concluding that a variety of work has been undertaken to support BCUHB primary care partners in increasing the uptake of the Pertussis vaccine in maternal women, and this will continue throughout the winter period. BCUHB have seen a decrease in uptake compared to last year, however, we remain confident that the supporting and control measures available will assist in increasing the uptake in this coming year. | Partial |
| 5 | WG24-22 | 24/06/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Supplementary Services) (Wales) Directions 2024                    | <a href="#">The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Supplementary Service) (Wales) Directions 2024</a>            | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No  | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DESSs) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DESSs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions.                                                                                                                                                                                                                                                            | Yes     |
| 6 | WG24-23 | 24/06/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Oral Anti-coagulation with Warfarin) (Directed Supplementary Service) (Wales) Directions 2024                       | <a href="#">The Primary Medical Services (Oral Anti-coagulation with Warfarin) (Directed Supplementary Services) (Wales) Directions 2024</a>                      | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No  | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DESSs) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DESSs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions.                                                                                                                                                                                                                                                            | Yes     |



|    |         |            |                                                                                                                                                                                                              |                                                                                                                                                                                 |                                                                              |                                                                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |     |
|----|---------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 7  | WG24-24 | 24/06/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Hormone Treatment Scheme for Adult Transgender Patients) (Directed Supplementary Service) (Wales) Directions 2024                 | <a href="#">The Primary Medical Services (Hormone Treatment Scheme for Adult Transgender Patients) (Directed Supplementary Service) (Wales) Directions 2024</a>                 | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DESS) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DESSs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions. | Yes |
| 8  | WG24-25 | 24/06/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Medical Services (Antivirals for Prophylaxis of Seasonal Influenza in Care Home Outbreaks) (Directed Supplementary Service) (Wales) Directions 2024 | <a href="#">The Primary Medical Services (Antivirals for Prophylaxis of Seasonal Influenza in Care Home Outbreaks) (Directed Supplementary Service) (Wales) Directions 2024</a> | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DESS) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DESSs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions. | Yes |
| 9  | WG24-26 | 24/06/2024 | The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024                                                                      | <a href="#">The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024</a>                         | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No | All these Directed Supplementary Services Directions (DSSs) used to be called Directed Enhanced Services Directions (DESS) prior to the change in GMS Contracts Regulations in 2023. The DSSs contain exactly the same service that GMS contractors had to provide under the DESSs. There is therefore no impact on services currently commissioned and they are continuing. The DSSs do however contain updated references, for example in the interpretation section of the DSSs reference is made to the GMS Contracts Regulations 2023 rather than the 2004 reference. The DSSs also contain transitional provisions. | Yes |
| 10 | WG24-28 | 05/07/2024 | Directions related to alternative provider medical services (Wales) Directions 2024.                                                                                                                         | <a href="#">The Alternative Provider Medical Services (Wales) Directions 2024</a>                                                                                               | Chris Stockport, Executive Director of Transformation and Strategic Planning | Lynne Joannou, Director Primary Care Contracting and Commissioning | No | The Directions provide the legislation for Health Boards to be able to commission APMS services. Currently within BCUHB there are no APMS contracts - no action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Yes |

|    |         |            |                                                                                                                                                                          |                                                                                                                                                 |                                                                              |                                                                                                                                                                 |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |
|----|---------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| 11 | WG24-38 | 23/08/2024 | THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024                                                 | <a href="#">The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024</a>                                                     | Chris Stockport, Executive Director of Transformation and Strategic Planning | Kailey Ben-Sassi, Lead Immunisation Pharmacist (with Lynne Joannou's Contracting Team offering support)                                                         | Yes     | <b>23/09/2024</b> - Lynne Joannou advised that this is about how the Organisation will commission the administration of the RSV vaccines. Kailey Ben-Sassi is leading on that but Lynne Joannou's contracting team support it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Partial |
| 12 | WG24-39 | 28/08/2024 | NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024 | <a href="#">The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024</a> | Chris Stockport, Executive Director of Transformation and Strategic Planning | <del>Lynne Joannou, Director Primary Care Contracting and Commissioning</del><br>Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning | Unknown | <b>25/09/2024</b> Forwarded to Lynne Joannou.<br><b>09/10/2024</b> Following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Chris Stockport and Lynne Joannou, deadline 16/10/2024.<br><b>16/10/2024</b> Update from Jane Trowman received: Representatives from the HB attending the national workshop in October, where the focus was on the Commissioning assessment tool. This is currently voluntary and not mandated. <b>The new guidance has been delayed until February 2025.</b> We will be prioritising 1 or 2 areas for an improvement plan/ year and will develop an internal action plan for implementation 24 /25. We will work with partners (LAs, providers, commissioning groups) to ensure how we evidence and learn from each other. Key priority areas will include market stability and flexibility, new ways of commissioning, service user involvement (what matters) and fair work in the sector. | Partial |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b><br><i>Report title:</i>                                                                                                                                                                                                                                                                                                                                                                                                     | Declarations of Interests/Gifts and Hospitality                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Adrodd i:</b><br><i>Report to:</i>                                                                                                                                                                                                                                                                                                                                                                                                               | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>                                                                                                                                                                                                                                                                                                                                                                                               | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i>                                                                                                                                                                                                                                                                                                                                                                                           | <p>The Board must ensure that the Health Board establishes and maintains a system for the declaration, recording and handling of Health Board officers' interests in accordance with the Values and Standards of Behaviour Framework.</p> <p>The purpose of this paper is to provide assurance and a position statement to the Audit Committee.</p> <p>A new electronic system widely used within the NHS was purchased from Civica called 'Declare' to capture all declarations. This was launched at the end of August 2023 and is available in both English and Welsh. This is being promoted to staff and managers to ensure that annual declarations are made and any gifts and hospitality are appropriately declared and Health Board is compliant.</p> <p>Link to Declare: <a href="https://mydeclarations.co.uk">Betsi Cadwaladr University Health Board (mydeclarations.co.uk)</a></p> |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Recommendations:</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | The Committee is asked to <b>receive</b> the report for assurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Executive Lead:</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | Pam Wenger, Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Report Author:</b>                                                                                                                                                                                                                                                                                                                                                                                                                               | Philippa Peake-Jones – Head of Corporate Affairs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>                                                                                                                                                                                                                                                                                                                                                                                            | <b>I'w Nodi</b><br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>I Benderfynu arno</b><br><i>For Decision</i><br><input type="checkbox"/>                                                                                                                                                                                      | <b>Am sicrwydd</b><br><i>For Assurance</i><br><input checked="" type="checkbox"/>                                                                                                                                                     |                                                                                                                                                                     |
| <b>Lefel sicrwydd:</b><br><i>Assurance level:</i>                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Arwyddocaol</b><br><i>Significant</i><br><input type="checkbox"/><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Derbyniol</b><br><i>Acceptable</i><br><input checked="" type="checkbox"/><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Rhannol</b><br><i>Partial</i><br><input type="checkbox"/><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Dim Sicrwydd</b><br><i>No Assurance</i><br><input type="checkbox"/><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><i>No confidence / evidence in delivery</i> |
| <p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><i>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:</i></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                     |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Partial assurance has been noted above because the system that has previously been invested in by the Health Board has only just been implemented and there needs to be a continued roll out of Information and engagement with it to ensure it is used effectively.</p> |                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><i>Link to Strategic Objective(s):</i></p>                                                                                                                                                                            | <p>This report is purely administrative. There are no associated strategy implications.</p>                                                                                                                                                                                                                                                                      |
| <p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><i>Regulatory and legal implications:</i></p>                                                                                                                                                                             | <p>This annual update is provided in order to comply with Standing Orders 8.1 – 8.7.</p>                                                                                                                                                                                                                                                                         |
| <p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>                                                                                              | <p>Do/Naddo    <b>Y/N</b></p> <p>Os naddo, rhwch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u></p> <p><u>WP7 Procedure for Equality Impact Assessments</u></p>                  |
| <p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>                                                                                               | <p>Do/Naddo    <b>Y/N</b></p> <p>Os naddo, rhwch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u></p> <p><u>WP68 Procedure for Socio-economic Impact Assessment.</u></p> |
| <p><b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b></p>                                                                                                                                | <p>N/A</p>                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>Financial implications as a result of implementing the recommendations</b></p>                                                                                                                                                                                        | <p>N/A</p>                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>Workforce implications as a result of implementing the recommendations</b></p>                                                                                                                                                                                        | <p>Relevant staff are obliged to make declarations of interest and any gifts and hospitality received or declined.</p>                                                                                                                                                                                                                                           |
| <p><b>Links to BAF risks:</b><br/>(or links to the Corporate Risk Register)</p>                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Reason for submission of report to confidential board (where relevant)</b></p>                                                                                                                                                                                        | <p>N/A</p>                                                                                                                                                                                                                                                                                                                                                       |

***Next Steps:***

Ensure that the updated policy is approved through the internal mechanisms and shared and the new PADR form includes a Declarations of Interest area for completion.

**Rhestr o Atodiadau:*****List of Appendices:***

Appendix 1 – Standards of Business Conduct (SOBC) Internal Audit Action plan tracker  
Appendix 2 – DOI & Gifts and Hospitality SOP/Flow Chart including communications

## DECLARATIONS OF INTERESTS/GIFTS AND HOSPITALITY

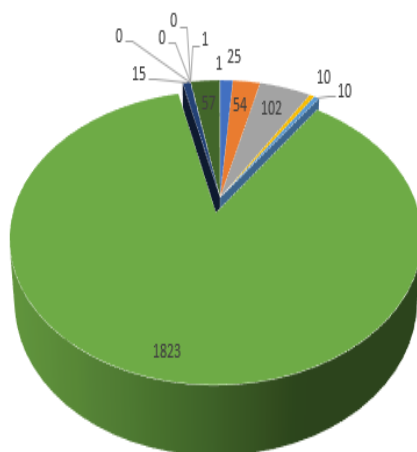
### 1. SITUATION

The purpose of this report is to update the Audit Committee on the progress made in relation to the monitoring of declaration on interest comparing with the interests declared for the year ending 2023/2024. The tables are broken down into Non Decision Makers (NDM) and Decision Makers (DM), the latter being identified as 8C and above.

#### Declarations Type Report - Financial Year 2023/2024

| Interest Type                                                                                | Declarations | NDM Staff | DM Staff |
|----------------------------------------------------------------------------------------------|--------------|-----------|----------|
| Anrhegion/Gifts                                                                              | 25           | 22        | 3        |
| Buddiannau teyrngarwch/Loyalty Interests                                                     | 54           | 21        | 33       |
| Cyflogaeth allanol/Outside Employment                                                        | 102          | 46        | 56       |
| Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests | 10           | 2         | 8        |
| Digwyddiadau a Noddir/Sponsored Events                                                       | 10           | 2         | 8        |
| Dim buddiannau i'w datgan/Nil Declaration                                                    | 1823         | 1197      | 626      |
| Lletygarwch/Hospitality                                                                      | 15           | 5         | 10       |
| No Change to existing declarations                                                           | 0            | 0         | 0        |
| Patentau/Patents                                                                             | 0            | 0         | 0        |
| Rhoddion/Donations                                                                           | 0            | 0         | 0        |
| Swyddi a noddir/Sponsored Posts                                                              | 1            | 0         | 1        |
| Ymarfer Clinigol Preifat/Clinical Private Practice                                           | 57           | 25        | 32       |
| Ymchwil a Noddir/Sponsored Research                                                          | 1            | 0         | 1        |
| Cyfanswm/Total                                                                               | 2098         | 1320      | 778      |

#### Declarations Type Report - Financial Year 2023/2024



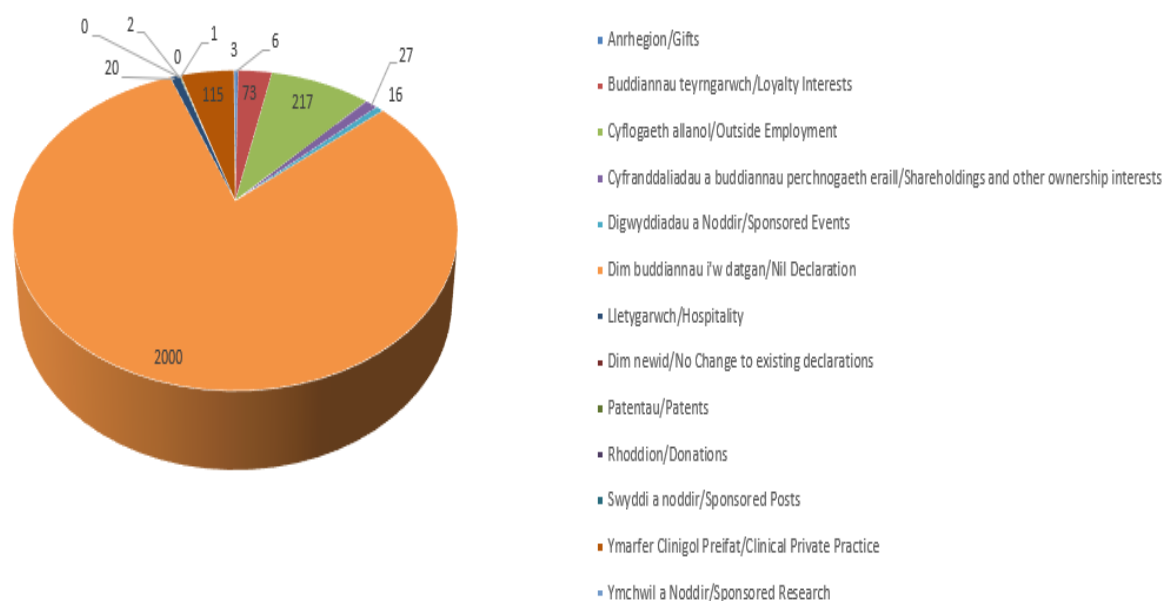
- Anrhegion/Gifts
- Buddiannau teyrngarwch/Loyalty Interests
- Cyflogaeth allanol/Outside Employment
- Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests
- Digwyddiadau a Noddir/Sponsored Events
- Dim buddiannau i'w datgan/Nil Declaration
- Lletygarwch/Hospitality
- No Change to existing declarations
- Patentau/Patents
- Rhoddion/Donations
- Swyddi a noddir/Sponsored Posts
- Ymarfer Clinigol Preifat/Clinical Private Practice
- Ymchwil a Noddir/Sponsored Research



## Declarations Type Report - Financial Year 2024/2025 as at 24/10/2024

| Interest Type                                                                                | Declarations | NDM Staff | DM Staff |
|----------------------------------------------------------------------------------------------|--------------|-----------|----------|
| Anrhegion/Gifts                                                                              | 6            | 2         | 4        |
| Buddiannau teyrngarwch/Loyalty Interests                                                     | 73           | 12        | 61       |
| Cyflogaeth allanol/Outside Employment                                                        | 217          | 68        | 149      |
| Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests | 27           | 4         | 23       |
| Digwyddiadau a Noddir/Sponsored Events                                                       | 16           | 1         | 15       |
| Dim buddiannau i'w datgan/Nil Declaration                                                    | 2000         | 352       | 1648     |
| Lletygarwch/Hospitality                                                                      | 20           | 2         | 18       |
| No Change to existing declarations                                                           | 0            | 0         | 0        |
| Patentau/Patents                                                                             | 2            | 0         | 2        |
| Rhoddion/Donations                                                                           | 0            | 0         | 0        |
| Swyddi a noddir/Sponsored Posts                                                              | 1            | 0         | 1        |
| Ymarfer Clinigol Preifat/Clinical Private Practice                                           | 115          | 26        | 89       |
| Ymchwil a Noddir/Sponsored Research                                                          | 3            | 0         | 3        |
| Cyfanswm/Total                                                                               | 2480         | 467       | 2013     |

Declarations Type Report - Financial Year 2024/2025 as at 24/10/2024



## 2. BACKGROUND

The Audit Committee are aware that the Civica system was launched at This was launched at the end of August 2023 and further work to embed and utilise the system more has taken place throughout 2024. The system is now updated at the beginning of every month with ESR data provided by the Workforce team, the line manager approval function has been enabled and regular reminders are issued. The

system is monitored on a weekly basis by the Corporate Governance Team and users have a direct access for support should they need anything.

An Internal Audit took place earlier in the year and an action plan was formed to address the findings and associated action can be found in **Appendix 1**.

### **3. GOVERNANCE**

Every Board member and Health Board officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused.

The Director of Corporate Governance, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

Governance Leads are assigned for Directorates and declarations of interests are routed through these leads for approval/escalation. Following on from the recommendations in a previous audit, all gifts and hospitality declarations are now also routed to the Director of Corporate Governance

The Audit Committee will review and report to the Board upon the adequacy of the HB arrangements for:

- dealing with offers of gifts, hospitality and sponsorship
- declaring, registering and handling interests

The Corporate Governance Directorate recognises that there is still more work to do in terms of the monitoring of declaration of interests and gifts and hospitality. This is part of the ongoing development of strengthening the governance and reporting in this area. In accordance with the cycle of business, the Audit Committee will receive regular updates on progress.

### **4. CONCLUSION**

This report gives an update to the committee on the number and type of declarations received. The Standard of Business Conduct Policy has been updated to address the findings from the internal audit review. A clear flow chart including a communication plan has been drafted which can be seen in Appendix 2. There is agreement to ensure that the new PADR form includes a Declarations of Interest check.

## Appendix 1 – Actions agreed following the Internal Audit on the SOBC

| No | Action                                                                                                                                                                                         | Date            | Complete                                                                                                                                                                                                                                          |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1  | Identify temporary support within the Corporate Governance Directorate to support the Declarations work                                                                                        | 1 June 2024     | Yes                                                                                                                                                                                                                                               |
| 2  | Review and update Policy to ensure that it is in line with the rest of Wales                                                                                                                   | 23 October 2024 | Yes<br>Policy now amended and going through the internal approval. It now reflects declarations for 8c and above as per the rest of Wales – the policy will be reviewed again as part of a piece of work that is ongoing on an all-Wales basis    |
| 3  | Review Policy to ensure that the pay bands are consistent with the rest of Wales                                                                                                               | 31 October 2024 | Yes<br>Policy now amended and going through the internal approval. It now reflects the 8c and above as per the rest of Wales – the policy will be reviewed again as part of a piece of work that is ongoing on an all-Wales basis                 |
| 4  | Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.                                                   | 31 July 2024    | Yes<br><br>This has been agreed by the Director of Peoples Services                                                                                                                                                                               |
| 5  | Communication briefing to all managers on responsibilities in relation to Declarations of Interest                                                                                             | 30 Sept 2024    | Yes<br><br>Communications go out via the Declare system                                                                                                                                                                                           |
| 6  | Review monthly scheduled notifications                                                                                                                                                         | 31 July 2024    | Yes – these go out monthly and are monitored                                                                                                                                                                                                      |
| 7  | Review monthly scheduled notifications                                                                                                                                                         | 31 July 2024    | Yes – reviewed and monitored                                                                                                                                                                                                                      |
| 8  | Review monthly published data to ensure that it is accurate and can be reconciled to source data.                                                                                              | 31 July 2024    | Yes – reviewed and monitored                                                                                                                                                                                                                      |
| 9  | Review published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. A meeting with Declare has already been arranged for Friday 14 June 2024 | 31 October 2024 | Yes – removed 16.9.24                                                                                                                                                                                                                             |
| 10 | Update Cycles of business and submit to the Audit Committee twice a year                                                                                                                       | 18 July 2024    | Yes – updated                                                                                                                                                                                                                                     |
| 11 | Monitor and review declarations on a weekly basis                                                                                                                                              | 31 July 2024    | Yes – these are monitored on an almost daily basis                                                                                                                                                                                                |
| 12 | Produce a targeted communication campaign and implement                                                                                                                                        | 30 July 2024    | Yes Regular communications are sent via the intranet and line managers are requested to authorise all Declarations (this was not taking place when the Audit happened). Further communication will take place when the refreshed policy goes live |
| 13 | Ensure Board Member interests be uploaded publicly when received.                                                                                                                              | Ongoing         | Yes<br>Board Members were all written to as part of the Annual Report work and their declarations were all updated.                                                                                                                               |

|    |                                                                                                                                          |                       |                                                                                                                                                             |
|----|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14 | Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities.) | 31<br>October<br>2024 | Complete<br>As per Appendix 2                                                                                                                               |
| 15 | Work with the Workforce Directorate on options around including Declarations on PADR templates                                           | TBC                   | This is ongoing and will be included in the PADR refresh. This has been agreed by the Deputy Director of People that they can be amended.                   |
| 16 | Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)   | Ongoing               | Complete<br>These are reviewed on a weekly basis by Corporate Governance and followed up – up to date ESR data is received at the beginning of every month. |
| 17 | Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity.                         | 31<br>October<br>2024 | Complete<br>As per Appendix 2                                                                                                                               |
| 18 | Produce a communications plan to raise awareness and compliance                                                                          | Ongoing               | Complete<br>As per Appendix 2                                                                                                                               |

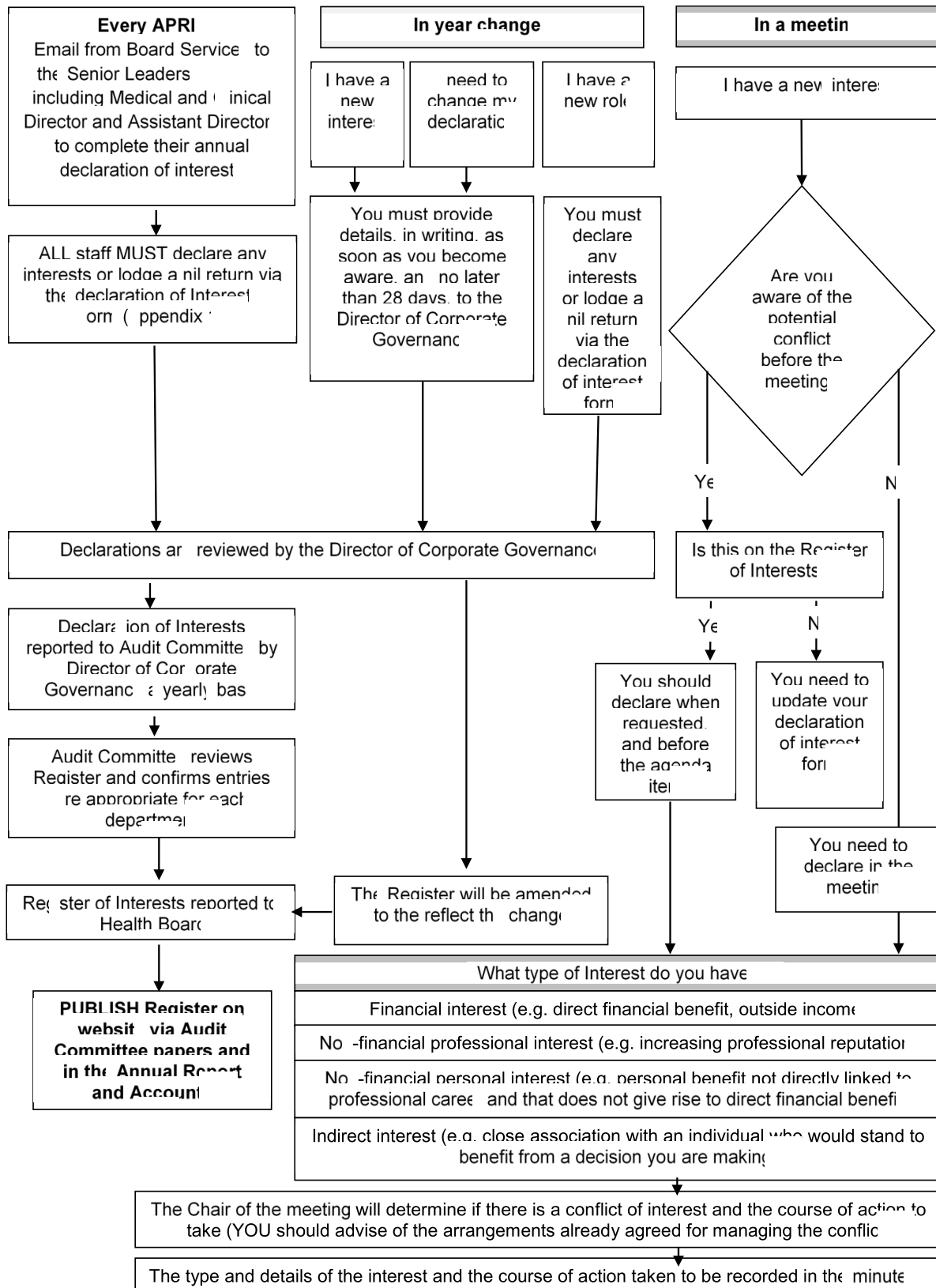


GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## Appendix 2

### Declaration of Interest Flowchart

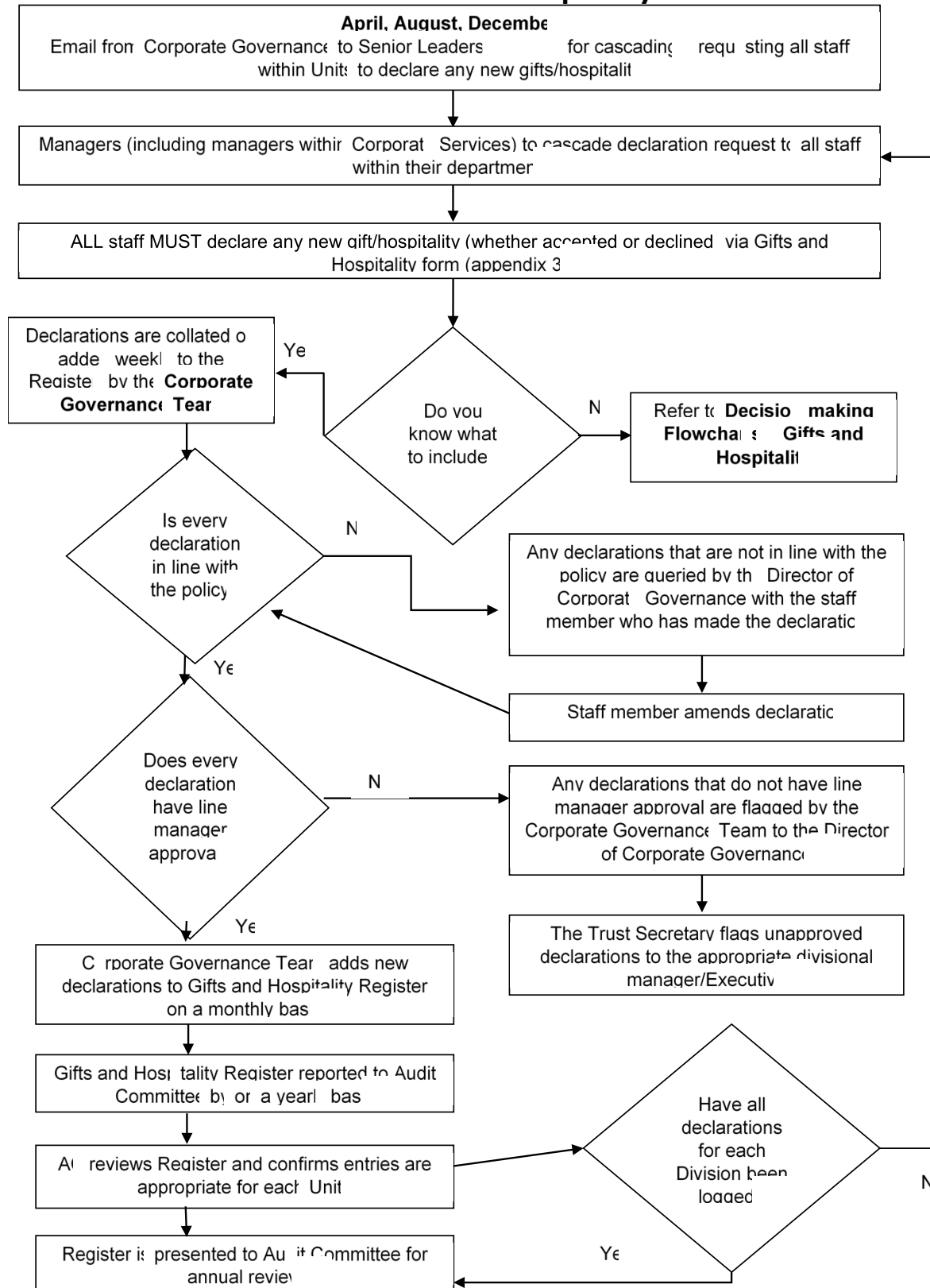




GIG  
CYMRU  
NHS  
WALES

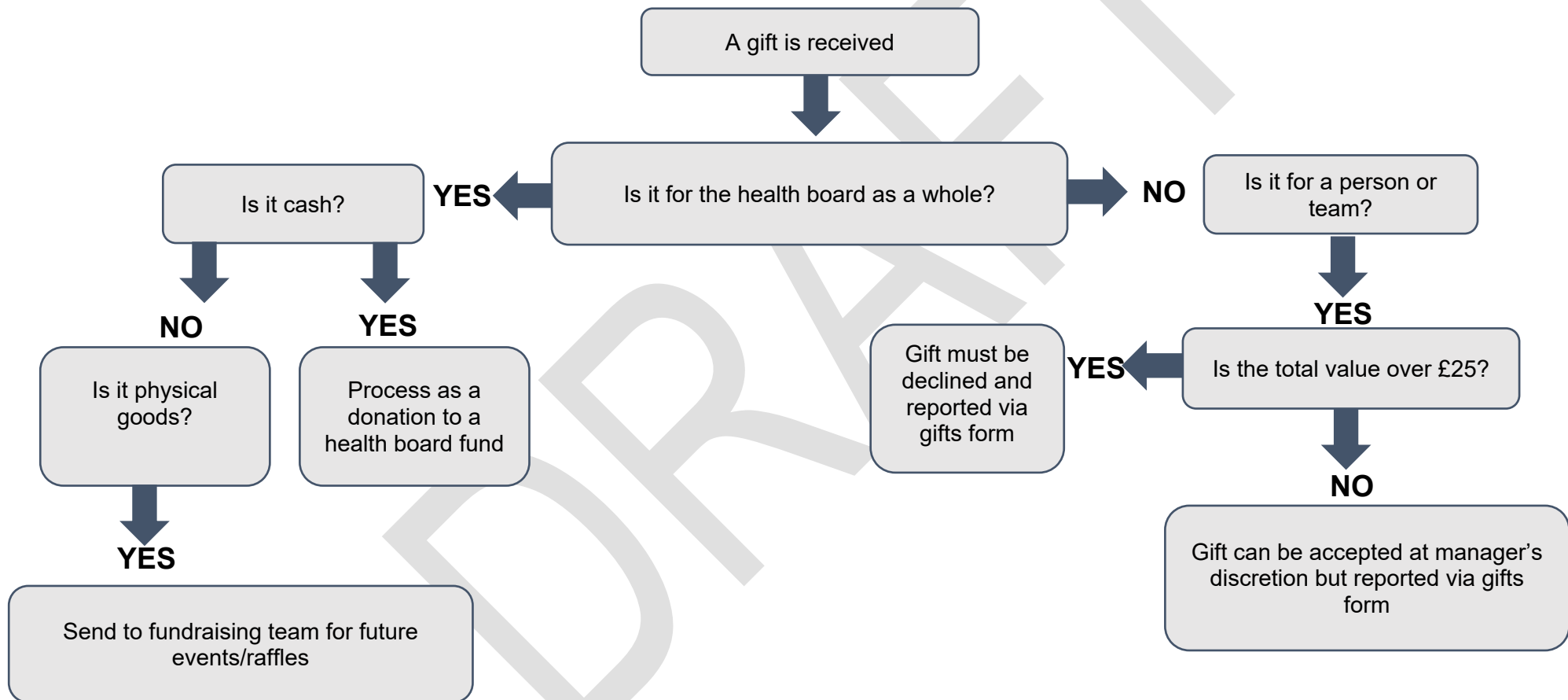
Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## Declarations of Gifts and Hospitality Flowchart





### Guidance for receiving Gifts





|                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b><br><i>Report title:</i>                                                                                                                                                                     | Minor changes to the Scheme of Delegation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Adrodd i:</b><br><i>Report to:</i>                                                                                                                                                                               | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>                                                                                                                                                               | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i>                                                                                                                                                           | <p>The following changes have been made to the Appendices to the Scheme of Delegation to ensure they are up to date :</p> <ul style="list-style-type: none"> <li>• Changed Board Secretary to Director of Corporate Governance in Table A and B</li> <li>• Changed legal authorities from Medical to Corporate Governance</li> <li>• Simplified both wording and authorisation levels for claims payments – but for balance added a new caveat that where a payment is contrary to legal advice, it needs two signatories rather than one and one of these two must be either Director of Corporate Governance or the Deputy Director of Legal Services to simplify the process but give a greater level of sign off when acting outside legal advice</li> <li>• Changed the approval of legal documents to say if contrary to legal advice, the matter is reserved for the CEO</li> </ul> |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Argymhellion:</b><br><i>Recommendations:</i>                                                                                                                                                                     | <ul style="list-style-type: none"> <li>• <b>SUPPORT</b> the changes to the Scheme of Delegation for onward consideration and approval by the Audit Committee</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Arweinydd Gweithredol:</b><br><i>Executive Lead:</i>                                                                                                                                                             | Pam Wenger, Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Awdur yr Adroddiad:</b><br><i>Report Author:</i>                                                                                                                                                                 | Philippa Peake-Jones, Head of Corporate Affairs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>                                                                                                                                                            | <p>I'w Nodi<br/><i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <p>I Benderfynu arno<br/><i>For Decision</i></p> <p><input type="checkbox"/></p>                                                                                                                                                                                              | <p>Am sicrwydd<br/><i>For Assurance</i></p> <p><input type="checkbox"/></p>                                                                                                                                                                        |                                                                                                                                                                                  |
| <b>Lefel sicrwydd:</b><br><i>Assurance level:</i>                                                                                                                                                                   | <p>Arwyddocaol<br/><i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Derbyniol<br/><i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Rhannol<br/><i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Dim Sicrwydd<br/><i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p> |
| <p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                    |                                                                                                                                                                                  |

|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>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:</b> |                                                                                                                                                                                                                                                                |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b>                                                                                                                                                                              | 1 Building and Effective Organisation                                                                                                                                                                                                                          |
| <b>Link to Strategic Objective(s):</b>                                                                                                                                                                                   |                                                                                                                                                                                                                                                                |
| <b>Goblygiadau rheoleiddio a lleol:</b>                                                                                                                                                                                  | The changes as highlighted in this paper are within the legal framework.                                                                                                                                                                                       |
| <b>Regulatory and legal implications:</b>                                                                                                                                                                                |                                                                                                                                                                                                                                                                |
| <b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b>                                                                                                                                                | Not required for this change.                                                                                                                                                                                                                                  |
| <b>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</b>                                                                                                                                   |                                                                                                                                                                                                                                                                |
| <b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>                                                                                                                                               | None identified                                                                                                                                                                                                                                                |
| <b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>                                                                                                                                     |                                                                                                                                                                                                                                                                |
| <b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>                                                                                  | None identified. There are risks should the Health Board not make the appropriate changes to the Standing Orders, this paper however, ensure that the appropriate changes are made in accordance with good governance practice and within the legal framework. |
| <b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>                                                                                    |                                                                                                                                                                                                                                                                |
| <b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>                                                                                                                                                    | None identified.                                                                                                                                                                                                                                               |
| <b>Financial implications as a result of implementing the recommendations</b>                                                                                                                                            |                                                                                                                                                                                                                                                                |
| <b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>                                                                                                                                                    | None identified for this report.                                                                                                                                                                                                                               |
| <b>Workforce implications as a result of implementing the recommendations</b>                                                                                                                                            |                                                                                                                                                                                                                                                                |
| <b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>                                                                                                                                                              | The changes to the Scheme of Delegation have been shared with the Director of Finance and agreed to undertake a wider review of the Scheme of Delegation.                                                                                                      |
| <b>Feedback, response, and follow up summary following consultation</b>                                                                                                                                                  |                                                                                                                                                                                                                                                                |
| <b>Cysylltiadau â risgiau BAF:</b><br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)                                                                                                                                 | None identified                                                                                                                                                                                                                                                |
| <b>Links to BAF risks:</b><br>(or links to the Corporate Risk Register)                                                                                                                                                  |                                                                                                                                                                                                                                                                |
| <b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>                                                                                                                                          | This paper will be available in public.                                                                                                                                                                                                                        |
| <b>Reason for submission of report to confidential board (where relevant)</b>                                                                                                                                            |                                                                                                                                                                                                                                                                |
| <b>Next Steps:</b><br><b>Implementation of recommendations</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                |

***List of Appendices:***

Appendix A – Updated Table A

Appendix B – Updated Table B

## **MINOR CHANGES TO THE SCHEME OF DELEGATION**

### **1. SITUATION**

The purpose of this report is to seek the support of the Audit Committee to propose changes to the Scheme of Delegation in relation to transfer of Legal Services from the Medical Director to the Director of Corporate Governance.

### **2. BACKGROUND**

The Board has approved Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved for the Board, a detailed scheme of delegation to officers and Standing Financial conduct of the Health Board and define “its ways of working”.

Director of Finance and the Director of Corporate Governance are undertaking the annual review of the Scheme of Delegation and a further proposal on any changes will be considered by the Audit Committee in January 2024.

### **3. GOVERNANCE AND RISK**

The Audit and Risk Committee has responsibility on behalf of the Board to review and consider the Governance Framework for the Health Board, this includes the Standing Orders and Scheme of Delegation.

The Director of Corporate Governance took on responsibility for Legal Services on 1<sup>st</sup> October 2024 and therefore changes to the Scheme of Delegation are required. These changes are set out below:

- Changed Board Secretary to Director of Corporate Governance in Table A and B
- Changed legal authorities from Medical Director to Corporate Governance
- Simplified both wording and authorisation levels for claims payments – but for balance added a new caveat that where a payment is contrary to legal advice, it needs two signatories rather than one and one of these two must be either Director of Corporate Governance or the Deputy Director of Legal Services to simplify the process but give a greater level of sign off when acting outside legal advice
- Changed the approval of legal documents to say if contrary to legal advice, the matter is reserved for the CEO

As part of the transfer of the Legal Services function to the Director of Corporate Governance, work will be undertaken to review the processes in relation to the settlement of claims in particular and any proposed changes will be considered as part of the wider review of the Scheme of Delegation

### **4. CONCLUSION**

This report has outlined the proposed changes to the Scheme of Delegation to take account the changes in relation to the transfer of legal services to the Director of Corporate Governance.

## 5. RECOMMENDATIONS

Members are asked to:

- **SUPPORT** the changes to the Scheme of Delegation for onward consideration and approval by the Audit Committee





|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                      |                                                                            |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b><br><i>Report title:</i>           | <b>Response to Freedom of Information Request 1552066</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                      |                                                                            |
| <b>Adrodd i:</b><br><i>Report to:</i>                     | <b>Audit Committee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      |                                                                            |
| <b>Dyddiad y Cyfarfod:</b><br><i>Date of Meeting:</i>     | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                      |                                                                            |
| <b>Crynodeb Gweithredol:</b><br><i>Executive Summary:</i> | <p>The purpose of this report is for the Audit Committee to consider and review the governance of the response to an FOI request related to the Health Board's partial funding of the Centre for Mental Health and Society (CfMHaS). The Health Board has had an agreement with Bangor University since July 2012 and provides grant funding to support the work of the CfMHaS. The nature of that work is detailed in Appendix 1.</p> <p>FOI Request 1552066 was received into the Health Board on 21 March 2024. The Health Board responded to the FOI Request on 17 September 2024 to the requestor and Llais. In addition to this a meeting was held with the individual who made the request on the 24<sup>th</sup> September 2024. The Response to the request is Attached in Appendix 1.</p> <p>In broad terms the matters in the response to the FOI Request related to payments to BCUHB members of staff, the arrangements between BCUHB and Bangor University and the activity of the CfMHaS. This resulted in an internal review into the current use of resources.</p> <p>This paper seeks to give assurance to the Audit Committee on the processes that were followed to complete the response by;</p> <ul style="list-style-type: none"><li>• Setting out the governance processes that were followed in checking the information contained in the response.</li><li>• Reporting on the outcome of Counter Fraud investigations</li><li>• Adherence of the signing off of Agreements with the Health Board's Scheme of Delegation.</li></ul> |                                                                      |                                                                            |
| <b>Argymhellion:</b><br><i>Recommendations:</i>           | <p>The Committee is asked to:</p> <ul style="list-style-type: none"><li>• consider and review the governance of the response to an FOI request related to the Health Board's partial funding of the Centre for Mental Health and Society (CfMHaS).</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                      |                                                                            |
| <b>Arweinydd Gweithredol:</b><br><i>Executive Lead:</i>   | Russell Caldicott - Executive Director of Finance<br>Pam Wenger - Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |                                                                            |
| <b>Awdur yr Adroddiad:</b><br><i>Report Author:</i>       | Phil Meakin – Associate Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      |                                                                            |
| <b>Pwrpas yr adroddiad:</b><br><i>Purpose of report:</i>  | I'w Nodi<br><i>For Noting</i><br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | I Benderfynu arno<br><i>For Decision</i><br><input type="checkbox"/> | Am sicrwydd<br><i>For Assurance</i><br><input checked="" type="checkbox"/> |

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| <b>Lefel sicrwydd:</b><br><b>Assurance level:</b>                                                                                                                                                                                                                                                                                                                                                                                        | <b>Arwyddocaol</b><br><b>Significant</b><br><input type="checkbox"/><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | <b>Derbyniol</b><br><b>Acceptable</b><br><input type="checkbox"/><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i>                                 | <b>Rhannol</b><br><b>Partial</b><br><input checked="" type="checkbox"/><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Dim Sicrwydd</b><br><b>No Assurance</b><br><input type="checkbox"/><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><i>No confidence / evidence in delivery</i> |
| <b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b><br><b>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:</b> |                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b><br><b>Link to Strategic Objective(s):</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                      | 1. Building an Effective Organisation<br>2. Compassionate Culture, leadership and engagement<br>4. Improving quality, outcomes and experience                                                                                                                                         |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |
| <b>Goblygiadau rheoleiddio a lleol:</b><br><b>Regulatory and legal implications:</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      | This paper relates to an FOI request that was received to allocation of funding to the Centre for Mental Health and Society. In this respect the response to this Health Board reviewed how effectively Health Board regulations were enacted in the oversight of these arrangements. |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |
| <b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b><br><b>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</b>                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                      | No<br>This report does not propose or review any new or existing policies, practices, events or decision-making processes that need to be reviewed for fairness and does not present barriers to participation or disadvantage any protected groups from participation.               |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |
| <b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b><br><b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                      | No<br>There are no potential socio-economic and cultural impacts of a proposed development on the lives and circumstances of people, their families and their communities.                                                                                                            |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |
| <b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      | CRR 24-04 – Learning                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                  |                                                                                                                                                                     |

|                                                                                                                                                                                       |                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b>                                          |                                                                                                                                                                                                                  |
| <b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b><br><br><b><i>Financial implications as a result of implementing the recommendations</i></b>                     | The report relates to payments that are made from the Health Board to Bangor University for the Centre for Mental Health and Society. The implications relate to the appropriateness of payments made to Cf MHaS |
| <b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b><br><br><b><i>Workforce implications as a result of implementing the recommendations</i></b>                     | None at this point                                                                                                                                                                                               |
| <b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b><br><br><b><i>Feedback, response, and follow up summary following consultation</i></b>                                     | This paper has been prepared following the response to the FOI Request. A meeting took place with the FOI Requestor in September 2024 and this is reflected in the report.                                       |
| <b>Cysylltiadau â risgiau BAF:</b><br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br><b><i>Links to BAF risks:</i></b><br><i>(or links to the Corporate Risk Register)</i> | Awaiting BAF approval in November Audit Committee.                                                                                                                                                               |
| <b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b><br><br><b><i>Reason for submission of report to confidential board (where relevant)</i></b>           | Not applicable                                                                                                                                                                                                   |
| <b><i>Next Steps:</i></b><br><i>Implementation of recommendations</i>                                                                                                                 |                                                                                                                                                                                                                  |
| <b><i>List of Appendices:</i></b><br>Appendix 1 – Copy of the FOI 1552066 Response                                                                                                    |                                                                                                                                                                                                                  |

**AUDIT COMMITTEE  
5 NOVEMBER 2024  
HEALTH BOARD RESPONSE**

**TO FREEDOM OF INFORMATION REQUEST 1552066**

**1.INTRODUCTION**

The purpose of this report is for the Audit Committee to consider and review the governance of the response to an FOI request related to the Health Board's partial funding of the Centre for Mental Health and Society (CfMHaS). The Health Board has had an agreement with Bangor University since July 2012 and provides grant funding to support the work of the CfMHaS.

FOI Request 1552066 was received into the Health Board on 21 March 2024. The Health Board responded to the FOI Request on 17 September 2024 to the requestor and Llais. In addition to this a meeting was held with the individual who made the request on the 24<sup>th</sup> September 2024. The Response to the request is Attached in Appendix 1.

In broad terms the matters in the response to the FOI Request related to payments to BCUHB members of staff, the arrangements between BCUHB and Bangor University and the activity of the CfMHaS. An internal review of the current use of resources was undertaken to inform the response provided to the requestor.

This paper seeks to give assurance to the Executive Team and the Audit Committee on the processes that were followed to complete the response by;

- Setting out the governance processes that were followed in checking the information contained in the response.
- Reporting on the outcome of Counter Fraud investigations
- Adherence of the signing off of Agreements with the Health Board's Scheme of Delegation.

**2.THE GOVERNANCE PROCESSES THAT WERE FOLLOWED IN CHECKING THE INFORMATION CONTAINED IN THE RESPONSE**

**2.1 The BCUHB FOI process.**

A timeline of the responses and communications has been logged by the Health Board Information Governance Team. It contains over 45 entries starting on the 29 February 2024 and ending on the 14 July 2024.

The response took longer than the Health Board standard response time. The Health Board aims to provide a response to an FOI request within 20 working days. However, in exceptional cases it may not be possible to provide a full response within 20 working days. For instance, if a case is complicated or raises issues which require detailed consideration. If the Health Board needs more time to undertake a review it will contact the requestor and give an estimate of when to receive a response. In this case it was agreed to undertake an Internal Review on 4 April 2024 and this was communicated to the FOI Requestor.

**2.2 Undertaking the Internal Review**

As noted above it was agreed to undertake an Internal Review overseen by the Interim Executive Director of Finance. The outcome of this Internal Review was completed by 10 September 2024 and a letter with the outcome of the review as send on 17 September 2024 to the requestor. The following action was taken as part of that review;

### **2.2.1 BCUHB reviewed information with Bangor University**

A request was made that to provide;

- A breakdown of roles/names that are associated with the CfMHaS and confirmation as to the direct employer was.
- Whether any of the funding that the Health Board provides is paid direct to the individuals or are the only payments they receive from this work is from their salaried employment?

Written responses were requested and received from Bangor University during this internal review. They evidence that there are four roles associated with the CfMHaS that are currently employed through Bangor University. The information demonstrates that individuals do not gain additional personal income from their involvement with CfMHaS either from Bangor University or the Health Board. The only payments they receive are through their salaried employment with the University. They are:

- 1 WTE professor of Psychiatry
- Two research officers/fellows
- One part time Senior Researcher

### **2.2.2 Declaration of Interest Process**

The Directorate of Corporate Governance undertook a review of any related Declarations of Interest (DOI) of the BCUHB MH&LD Medical Director. There are three entries in the DOI register.

- 13/9/2023 – Nil Declaration
- 7/10/23 – Registered attendance at a Sponsored Event (unrelated to this matter)
- 3/6/2024 – Nil Declaration

Since this review has concluded there is a meeting established with the Directorate of Corporate Governance and this Medical Director to provide guidance on the standards of business conduct policy.

### **2.2.3 Companies House**

The Directorate of Corporate Governance undertook a review of people associated with CfMHaS that are documented with Companies House. No conflicting interests were found.

## **3.OUTCOME OF COUNTER-FRAUD INVESTIGATIONS**

The review as to whether there has been fraudulent activity has been reviewed by National and Local Counter Fraud Teams. In addition Audit Wales had received correspondence on that matter. Their findings are reflected below.

### **3.1 National Counter-Fraud Team Wales Investigations**

The Counter Fraud Services (CFS) Wales Team had been contacted by a member of the public raising numerous and varied concerns centred around issues of probity, conflict of interest and the appropriate use of funding issued by Betsi Cadwaladr Health Board (BCUHB) to the Centre for Mental Health & Society. These concerns were reviewed by CFS Wales and the BCUHB LCFS Team and no economic crimes were identified. The individual continued to correspond regularly with CFS Wales and the LCFS Team, but importantly the assessment remains that there has been no fraudulent activity. The issues raised by the individual were referred to the Acting Board Secretary at BCUHB for review.

It was agreed that any future communication from the individual would be via the BCUHB Acting Board Secretary and that any economic crime concerns identified in the review would be referred by the Board Secretary (now Director Governance) to CFS Wales for further investigation.

### **3.2 Local Counter Fraud Team Investigations**

The FOI requestor has been in frequent email and phone contact regarding the funding of Centre for Mental Health & Society (CfMHaS) by the Health Board and the honorary roles that some senior BCUHB personnel also had at various Universities.

The initial concerns were reviewed by the Head and Deputy Head of the Local Counter Fraud Service at the Health Board and it was agreed that they were not fraud issues as the subjects had disclosed their secondary roles / employment. The CfMHaS financial funding concerns were reviewed and no issues of fraud identified.

Two examples of allegations that were considered are:

- There is no substance to the allegation that Health Board staff members are in paid employment for sitting on the Governing Body of Colleg Cambria.
- There is no substance to the allegation that Clinical Staff employed by the Health Board are working against the requirements of Welsh Government. Clinical Staff can contribute to medical articles in a clinical journal for the profession with academic institution and Health Board expected to have great integration (Betsi Cadwaladr University Health Board).

The Requestor was sending many emails to several persons at Health Board, Welsh Government, Audit Wales and Counter Fraud Services Wales; therefore they were informed that all correspondence should be sent to one person (the then Acting Board secretary at BCUHB) who would be the single point of contact for all correspondence from the Requestor.

### **3.3 Audit Wales Position**

During 2023 Audit Wales received correspondence setting out concerns in respect of the Health Board's funding arrangements for the Centre of Mental Health and Society (CfMHaS). The concerns variously related to a lack of clarity on how much funding the CfMHaS has received from the Health Board, what the funding has been used for, and the value obtained from that funding. Concerns were also raised about potential conflicts of interest in relation to the awarding of funding to the CfMHaS.

Audit Wales looked into the matter and was not able to find any evidence to substantiate the concerns raised. Following further exchanges with the correspondent Audit Wales ultimately concluded that the information provided did not justify any further external audit work, balancing a consideration of likely findings with the cost of the work that would be involved.

The Audit Wales Engagement Director for the Health Board wrote to the Chief Executive and Director of Finance on 1<sup>st</sup> November 2023 to set out the work undertaken in response to the correspondence, and what it had found. Whilst Audit Wales did not propose to undertake any further work in response to the correspondent's concerns, it did highlight the importance of the Health Board being able to demonstrate that the necessary internal controls and governance are in place in respect of the funds it provides to the CfMHaS,



and more specifically to ensure there are clear governance and accountability arrangements covering:

- the amounts given;
- the specific purposes for which the funds were given;
- the outcomes those funds achieve;
- the identification and management of any conflicts of interest
- compliance with BCUHB, Welsh Government and Charitable funding requirements
- prioritisation of on-going funding for the CfMHaS against competing priorities elsewhere in the context of the financial constraints within which the Health Board is operating

The Audit Wales Engagement Director suggested that the Health Board could usefully ask Internal Audit to examine the above issues to provide the necessary assurances. Audit Wales received a response from the Health Board's Finance Department on 8<sup>th</sup> November 2023 which indicated that the Health Board was content that there were no governance issues or conflicts of interest in relation to the funding of the CfMHaS and would therefore not be recommending any further review into the matter. The Health Board will continue to comply with the above governance and accountability arrangements.

#### **4.ADHERENCE TO THE HEALTH BOARD SCHEME OF DELEGATION**

The Internal Review has established that an ongoing agreement in place for the grant/funding that BCUHB that has been in place since 2013/14 and it has been funded from the Clinical Research budget for Mental Health and Learning Disability Services. This is enabled by Welsh Government ring fenced funding.

The BCUHB Finance Team have clarified that the Health Board is invoiced quarterly by the University for the funding for the CfMHaS. The Finance Team have also clarified that the authoriser of the Invoices is the Mental Health and Learning Disabilities Medical Director. The scheme of delegation sets out that the authorisation level for that role is £250k. Quarterly invoices approved have always been below this level since 2023/13 to 2024/25.

The current agreement will required to be extended and arrangements are being put in place to establish this.

#### **5.RECOMMENDATIONS**

The matters raised in this FOI Request and the Internal Review are useful reminders about how the importance of good governance and there are a number of improvements that can be made

- Reminding all employees of the Health Board asking to confirm if they have any pecuniary interests to declare (or potential perception of an interest to declare) and the process for doing so.
- Ensure that Senior Mental Health and Learning Disabilities staff are aware of the CfMHaS arrangements and to give guidance to those staff on the policy and process relating to Declarations of Interest.
- Ensure that future arrangements with Bangor University are formalised and that this is documented. In doing so, ensure that considerations suggested by Audit Wales above are considered.

## Appendix 1 – Copy of Written Response After Internal Review

Dear xxxxxx

### **Centre for Mental Health and Society**

I am writing to you in advance of our meeting on the 24 September 2024 at 3.30pm at Carlton Court, St Asaph with Geoff Ryall-Harvey (who is also copied into this letter). Please accept my apologies for the delay in responding to you on the information you have requested in accordance with the Freedom of Information Act.

I want to acknowledge that there have been a number of e-mails and requests for information in relation to the above, I hope that this letter addresses the matters you raised regarding Betsi Cadwaladr University Health Board's (BCUHB) funding of the Centre for Mental Health and Society (CfMHaS) based at Bangor University in a Freedom of Information Request (FOI) 1552006. As you are aware Russell Caldicott, Interim Executive Director of Finance has undertaken a review of the relevant information raised in the subsequent points of clarification. The meeting on the 24<sup>th</sup> September 2024 will give us the opportunity to take you through this review in more detail and address any points of clarification.

This detailed response centres on the FOI request referenced above. In broad terms the matters in the review examined payments made to BCUHB members of staff, the arrangements between BCUHB and Bangor University and the activity of the CfMHaS.

The letter sets out the response from the FOI Request 1552066 in three sections;

1. **The question you raised in your original FOI Request 1552066 (with the Health Board response from the 21 March 2024)**
2. **Points of clarification raised by you from 22 March 2024.**
3. **The response to these points from the review that was undertaken.**

### **Section 1 - The question you raised in your original FOI Request 1552066 (with the Health Board response from the 21 March 2024)**

Table 1 – FOI Request from 21 March 2024.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Question</b><br>The question is 'who' the money is for and what is it for, perhaps better which team and What Projects CfMHaS list on their website is it for, who might be a loaded term under FOI but in this case it is who at CfMHaS. So if you look at their Web site <a href="https://cfmhas.org.uk/status/current-projects/#">https://cfmhas.org.uk/status/current-projects/#</a> and Research current Projects the 'who' is which of these project teams is it paying for and/or which team of Professor and Three Researchers and what are they doing that warrants £3.2M diverting from NHS funds to an insolvent broke overspent NHS Health Board.                                    |
| <b>Response Provided On 21 March 2024</b><br><i>Researchers propose projects that go through independent panels, depending upon where funding is available. If successful, funding for the project is granted. The centre is responsible to use the money for the project and report regularly to the funder. Usually funding comes from the National Centre for Research, but it can be Universities, research councils, private companies, government, etc.</i><br><br><i>No money is kept by the Division, University or individuals. If any fund is left over, it is refunded to the sponsor. This method applies to any research project. If the centre is good, it attracts bigger funds.</i> |

## **Section 2 - Points of Clarification Raised by you from 22 March 2024**

Table 2 below sets out a response to the clarifications you raised from 22 March 2024. As you know we haven't responded to points yet owing to our looking to secure a meeting with you to discuss the responses as requested. Please find below responses to your questions which we can discuss at the meeting next week.

Table 2 – Points of Clarification

- **As per T/C the question is 'who' is it for and what is it for?**
- **Perhaps better which team and What Projects CfMHaS list on their website is it for?**
- **Who might be a loaded term under FOI but in this case it is who at CfMHaS?**
- **So if you look at their Web site <https://cfmhas.org.uk/status/current-projects/#>. and Research current Projects, the 'who' is which of these project teams is it paying for and/or which team of Professor and Three Researchers and what are they doing that warrants £3.2M diverting from NHS funds to a an insolvent broke overspent NHS Health Board?**
- **What are they working on? Health Care and Research Wales is funded by Health Care and Research Wales but go to site click on NHS TEWV and there is nothing there. South Asia Self harm initiative is funded by Global challenges research fund. Berwyn Prison is another separate 600k funding stream. SOCAP was funded by Welsh gov Ser Cymru. National centre for Mental Health is funded by UK Gov NIHR finding a way forward by Betsi Cadwaladr University Health Board, Research and Development Department Pathway to Portfolio Scheme.**
- **In short none of them are anything like a Prof and three researchers doing £3.2M worth of work of VFM benefit for Patients in North Wales. Nothing fits the Bill so why is the BCUHB Dir of MLD Medicine giving the BCUHB prof of Psychiatric Liaison (Wrexham) £3.2M?**

## **Section 3 - The response to these points from the review that was undertaken.**

### **3.a. As per T/C the question is 'who' is it for and what is it for? Perhaps better which team and what Projects CfMHaS list on their website is it for?**

In terms of “who is it for?”, the review that has been undertaken has concluded that the staff associated with the CfMHaS are currently employed by Bangor University with no individual from the Health Board receiving any additional payment (or any company related to those individuals from our investigations) for supporting the research for which the Health Board contributes annually. This currently provides the following posts:

- 1 WTE professor of Psychiatry
- two research officers/fellows
- one part-time Senior Lecturer in Psychiatry

In terms of “what it is for”?,

The major activities are:

- Suicide prevention.
  - CfMHaS has been working in suicide prevention for over a decade, initially in south Asia, then globally and, most recently, locally. All of this work has been funded by external grants.
  - Professor Poole sits on the Project Board of the National Confidential Inquiry into Patient Suicide and Safety in Mental Health.

- Developing and evaluating a new model of suicide prevention training for mental health staff in BCUHB.
- Systematic review and evidence synthesis on male suicide in Wales for Public Health Wales.
- Long term high dose opioid use.
  - North Wales has the only Prescribed Medication Service anywhere in the NHS, which is led by June Lovell. It works with GPs to help patients reduce and stop dependency forming medication.
- Offenders and prisons.
- Medical education
- Serious Incident Reviews.
  - Developed national policy on use of title 'Consultant Psychiatrist' (2017) and on the principles of good practice in serious incident reviews (2018).
- Psychiatric and research support to other BCUHB services
  - Evidence synthesis and evaluation within the Long Covid/Community Complex Conditions Service, led by Dr Rachel Skippon
  - The pre-pandemic frequent attenders service, led by Dr Rachel Skippon
  - WMH Cardiac Rehabilitation service led by Jacqui Cliff

CfMHaS has produced a large number of peer-reviewed publications in international journals, books chapters and three books with major academic publishers. The centre is very research active and over time has attracted millions of pounds in research grant capture. The latter may have led to misinterpretation of the financial commitment for people less familiar with the research environment. The level of grant capture has accelerated in recent times, and CfMHaS has recently secured NIHR grants to lead clinical trials of complex interventions in mental health.

### **3.b. Perhaps better which team and What Projects CfMHaS list on their website is it for?**

It is considered that points 3a above and 3d below cover this question.

### **3.c. Who might be a loaded term under FOI but in this case it is who at CfMHaS?**

The response to point 3a addresses this question. The review that has been undertaken has also concluded that staff currently associated with the CfMHaS are employed by Bangor University and no individual from the Health Board receives any additional payment (or any company related to those individuals for that matter) for supporting the research for which the Health Board contributes annually.

### **3.d. So if you look at their Web site <https://cfmhas.org.uk/status/current-projects/#>. and Research current Projects, the 'who' is which of these project teams is it paying for and/or which team of Professor and Three Researchers and what are they doing that warrants £3.2M diverting from NHS funds to a an insolvent broke overspent NHS Health Board?**

The commitment to the CfMHaS is a significant one and your letter has supported our continued evaluation of it. The detailed response to this above question is partly covered in point 3a and 3b above. In relation to the justification for the £3.2m being spent in this way the review adds the following points below as to the value the expenditure brings.

#### **Strategy Implications**

Research is an important component of any organisation and essential for clinical strategy, quality and safety. Furthermore, this small academic department has attracted significant grants over time, raising Bangor University and BCUHB profiles at international level. Having an academic department has helped to retain a number of consultants with a research interest that otherwise would have left North Wales to gravitate around other Universities.

#### **Current benefits linked to the Academic Department**

The Academic Department brings several direct benefits to BCUHB. This is just a summary of the main benefits that cannot be under-estimated. The list is not exhaustive. Please refer to literature for the general benefits of academic department in healthcare systems.

- **Financial:** As BCUHB provides funding to Bangor university for these posts, it may be erroneously interpreted as a sort of contribution without return. In actual fact, part of the budget is directly returned to BCUHB with the time that academics use for BCUHB functions, such as 1 session/week of direct clinical care is carried out by the Professor and it is often more than the agreed time.
- **Clinical:** The Academic Department has directly contributed to a number of policies and creation of new services, i.e.:
  - Opioid use in pain management: protocol, clinic and direct clinical input
  - Training for suicide prevention
  - High dose prescribed medication clinic: protocol, clinic and supervision
  - DIALOG+: currently introduced as a pilot in Flintshire CMHT

**Indirect benefits:** the Academic Department has contributed to significant improvements in a number of areas in MHLT:

- Psychiatric training: almost all trainees in North Wales have a scientific publication by the end of their training. This has helped retention and in combination with other changes, all training posts have been filled over the last four years, against a vacancy rate of up to 80% previously. This also had financial benefits
- Senior medical posts: we have attracted 3 consultants who were interested in research and teaching. There is a risk to the Health Board of losing these doctors if the Academic Department ceases. Research is an important element of our recruitment and retention of our clinicians and a key priority as part of the three year plan
- Links with other institutions: we have very strong links with Chester and Manchester Universities
- Evaluation of services: prison health prescribing (medicine reconciliation); primary care model; ICAN Work; opiate clinic; Long Covid
- Reputation: North Wales is considered the second best psychiatric research place in Wales

**3.e. What are they working on? Health Care and Research Wales is funded by Health Care and Research Wales but go to site click on NHS TEWV and there is nothing there. South Asia Self harm initiative is funded by Global challenges research fund. Berwyn Prison is another separate 600k funding stream. SOCAPp was funded by Welsh gov Ser Cymru. National centre for Mental Health is funded by UK Gov NIHR finding a way forward by Betsi Cadwaladr University Health Board, Research and Development Department Pathway to Portfolio Scheme.**

The information provided in Point 3a and 3d answers these points. The commitment to the CfMHaS is a significant one and your letter has supported our continued evaluation of it and the associated governance and communication processes related to the arrangements. The Health Board received the Annual Report on Research and Development in May 2024 which details more information about Research and Development across the Health Board.

**3.f. In short none of them are anything like a Prof and three researchers doing £3.2M worth of work of VFM benefit for Patients in North Wales. Nothing fits the Bill so why is the BCUHB Dir of MLD Medicine giving the BCUHB prof of Psychiatric Liaison (Wrexham) £3.2M?**

The review also examined the process by which the arrangements with Bangor University were entered into. The procurement departments from the University and BCUHB were involved in producing the agreement that is currently in place. At an earlier stage of CfMHaS development and in order to consolidate a developing portfolio, an application for a grant from BCUHB Charitable Funds was initially made to develop a new research centre that would be part of Bangor University, but which would support the work of clinical researchers in BCUHB. The bid was successful and £149,602 was provided to support the formation of the CfMHaS with no further allocations by the Charity.

In relation to the Health Board Charity that I mention above, the Health Board are the Trustees of the Charity. As part of its responsibilities it has established a Charitable Funds Committee and it has been discharging its governance responsibilities appropriately and they are available to review and are available in the public domain. This includes the Committee and Grants Decision Making meeting. An Annual Report is produced at the end of each year. The Committee is chaired by an Independent Member, Councillor Dyfed Jones is the current Chair.

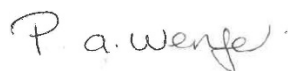
### **Summary**

I hope this written response in advance of our meeting on the 24 September 2024 addresses the points you have raised. At your request, Gareth Williams, Vice Chair will be at the meeting along with myself and Russell Caldicott to address any points of clarification you require.

If there are any points of clarity or outstanding matters then they can be discussed at the meeting and following that we will write to you with the outcome of the meeting.

Can I thank you once again for raising these matters and your patience and we look forward to seeing you on 24 September.

Yours sincerely



**Pam Wenger**  
**Cyfarwyddwr Llywodraethu Corfforaethol**  
**Director of Corporate Governance**



|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b><br><b>Report title:</b>           | <b>Conformance Report: Q2 2024/25</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Adrodd i:</b><br><b>Report to:</b>                     | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Dyddiad y Cyfarfod:</b><br><b>Date of Meeting:</b>     | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Crynodeb Gweithredol:</b><br><b>Executive Summary:</b> | <p>This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations.</p> <p>The areas covered in this report are:</p> <ul style="list-style-type: none"> <li> <b>Purchase orders that are non-compliant with SFI's (July to September 2024)</b> <p>This data set relates to orders being raised after the invoice has been received.</p> <p>Non-compliance for the period is 242 in July, 260 in August and 188 in September. The total 690 breaches during quarter 2 (Q2) is a material improvement compared to 1,145 in Q2 2023-24. A significant proportion of the orders are for known expenditure such as contractual clinical services, out of area treatments and computer software fees; however, the variable nature of the volume means that retrospective orders are produced.</p> <p>The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. In addition, Oracle IProc Refresher training sessions are again being offered this year, with two sessions in early October 24 being attended by over 460 staff.</p> <p>NHS Wales Shared Services Partnership (NWSSP) have finalised and approved the purchase order (PO) exemption list as part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.</p> <p>An all-Wales initiative to issue a standard financial guidance letter, drafted by NWSSP, setting out the expectation to comply with the requisition and order process was issued by the Executive Director of Finance to all budget managers within BCU, on 3<sup>rd</sup> September 2024.</p> </li> <li> <b>Single Waivers (July to September 2024)</b> <p>There has been a significant decrease in the number of approved waivers.</p> <p>Single Tenders – 8 approved in Q2, compared to 15 last year.</p> <p>Single Quote – 0 approved in Q2, compared to 15 last year.</p> </li> <li> <b>Receivables and conformance with payroll procedures</b> <p>The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.</p> <p>As at 30<sup>th</sup> September 2024, there were 3,141 outstanding invoices, totalling £10.2m, of which 628 invoices, totalling £4.6m were less than 30 days old.</p> <p>The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are</p> </li> </ul> |

|  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|  | <p>not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period.</p> <p>For the period July to September 2024 there were 110 staff overpayments, with a gross value of £0.209m, compared to 117 and £0.338m in the same period of the previous year. Failure to complete forms on time remains the main cause of overpayments (98 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.</p> <p>NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments.</p> <p>As at 30<sup>th</sup> September 2024 the balance outstanding was £1.127m, compared to £1.087 30<sup>th</sup> November 2023.</p> <ul style="list-style-type: none"> <li> <b>Payables and conformance with Public Sector Payment Policy (PSPP)</b> <p>The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The year to date achievement for non-NHS invoices by number is 96%.</p> </li> <li> <b>Losses and special payments</b> <p>Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).</p> <p>Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.</p> <p>Clinical negligence claims are managed by Legal and Risk Services and there were 306 active claims at the end of September 2024. Of these 128 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £160m (before reimbursement from the Welsh Risk Pool).</p> </li> <li> <b>Chairs Action in Quarter 2 2024/25</b> <p>There were no Chairs actions in relation to financial compliance during the period.</p> </li> <li> <b>Contract Procurement Review Update</b> <p>22 of the 24 actions are closed. Open actions relate to the following:</p> <ul style="list-style-type: none"> <li>Financial Procedures - Significant progress have been made during the past 6 months in updating 19 documents :2 complete, 1 New (dealing with changes to Delegated Limits), 14 are nearing completion following consultation, 1 has been amalgamated and 2 will be commence the review process later in Q3. The risk associated with the outdates procedures is considered low. The completion date is end of March 25, but the expectation is that this will finish in advance of that date.</li> </ul> </li> </ul> |
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Contract Register – all Divisions have been met with, to discuss the required minimum data set information. Evidence of progression is awaited now from just 4 Divisions and these are being progressed.</li> </ul>                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                               |
| <b>Argymhellion:</b><br><br><b>Recommendations:</b>                                                                                                                                                                                                                                                                                                                                                                                   | The Audit Committee is asked to:<br>1. To note and discuss the below elements of performance <ul style="list-style-type: none"> <li>Purchase orders that are non-compliant with SFI's</li> <li>E-Waiver System Developments and Single Waivers</li> <li>Receivables and conformance with payroll procedures</li> <li>Payables and conformance with Public Sector Payment Policy (PSPP)</li> <li>Contract Procurement Review Update</li> </ul> 2. Approve the Losses and Special Payments (July to September 2024) |                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                               |
| <b>Arweinydd Gweithredol:</b><br><b>Executive Lead:</b>                                                                                                                                                                                                                                                                                                                                                                               | Russel Caldicott, Interim Executive Director of Finance                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                               |
| <b>Awdur yr Adroddiad:</b><br><b>Report Author:</b>                                                                                                                                                                                                                                                                                                                                                                                   | Denise Roberts, Head of Capital, Business Improvement and Compliance<br>Andrea J Hughes, Interim Finance Director – Operational                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                               |
| <b>Pwrpas yr adroddiad:</b><br><b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                              | I'w Nodi<br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                              | I Benderfynu arno<br><i>For Decision</i><br><input checked="" type="checkbox"/>                                                                                                                                             | Am sicrwydd<br><i>For Assurance</i><br><input checked="" type="checkbox"/>                                                                                                |                                                                                               |
| <b>Lefel sicrwydd:</b><br><br><b>Assurance level:</b>                                                                                                                                                                                                                                                                                                                                                                                 | Arwyddocaol<br><i>Significant</i><br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Derbyniol<br><i>Acceptable</i><br><input checked="" type="checkbox"/>                                                                                                                                                       | Rhannol<br><i>Partial</i><br><input type="checkbox"/>                                                                                                                     | Dim Sicrwydd<br><i>No Assurance</i><br><input type="checkbox"/>                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       | Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>                                                                                                                                                                                                                                                                                                                                  | Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i>                                        | Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br><i>No confidence / evidence in delivery</i> |
| Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:<br><br><i>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:</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                               |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b><br><br><b>Link to Strategic Objective(s):</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose. |                                                                                                                                                                           |                                                                                               |
| <b>Goblygiadau rheoleiddio a lleol:</b><br><b>Regulatory and legal implications:</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.               |                                                                                                                                                                           |                                                                                               |
| <b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b><br><b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Not applicable                                                                                                                                                                                                              |                                                                                                                                                                           |                                                                                               |

|                                                                                                                                                                                                                                                                               |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?<br><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>                                                                                                                   | Not applicable                                                 |
| Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)<br><br><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i> | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.  |
| Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith<br><i>Financial implications as a result of implementing the recommendations</i>                                                                                                                               | Management of financial risk of not achieving value for money. |
| Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith<br><i>Workforce implications as a result of implementing the recommendations</i>                                                                                                                               | None                                                           |
| Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori<br><i>Feedback, response, and follow up summary following consultation</i>                                                                                                                                               | Not applicable                                                 |
| Cysylltiadau â risgiau BAF:<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><i>Links to BAF risks:</i><br>(or links to the Corporate Risk Register)                                                                                                                  | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.  |
| Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)<br><i>Reason for submission of report to confidential board (where relevant)</i>                                                                                                                     | Not applicable                                                 |
| Camau Nesaf:<br>Gweithredu argymhellion<br><i>Next Steps:</i><br><i>Implementation of recommendations</i> <ul style="list-style-type: none"> <li><i>The report is for noting and, in the case of losses and special payments, approval</i></li> </ul>                         |                                                                |
| Rhestr o Atodiadau:<br><i>List of Appendices:</i> <ol style="list-style-type: none"> <li>Conformance Report – Quarter 2 (July to September 2024).</li> </ol>                                                                                                                  |                                                                |

## Appendix 1 : Conformance Report – Quarter 2 (July to September 2024).

### Section 1 - Conformance with Procurement Procedures

#### a) SFI requirements

The Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs), set the minimum thresholds for quotes and competitive tendering. These thresholds reflect relevant regulatory requirements, and are summarised in the following table:

| Contract Value(ex VAT) | Minimum Competition                   |
|------------------------|---------------------------------------|
| <£5,000                | At discretion of appropriate Director |
| £5,000-£25,000         | 3 written quotations                  |

|                                           |                                      |
|-------------------------------------------|--------------------------------------|
| £25,000-OJEU threshold                    | 4 tenders                            |
| Above OJEU threshold (currently £118,133) | 5 tenders                            |
| Contracts between £500k and £1 million    | WG Ministerial Approval for noting * |
| Contracts above £1 million                | WG Ministerial Approval required *   |

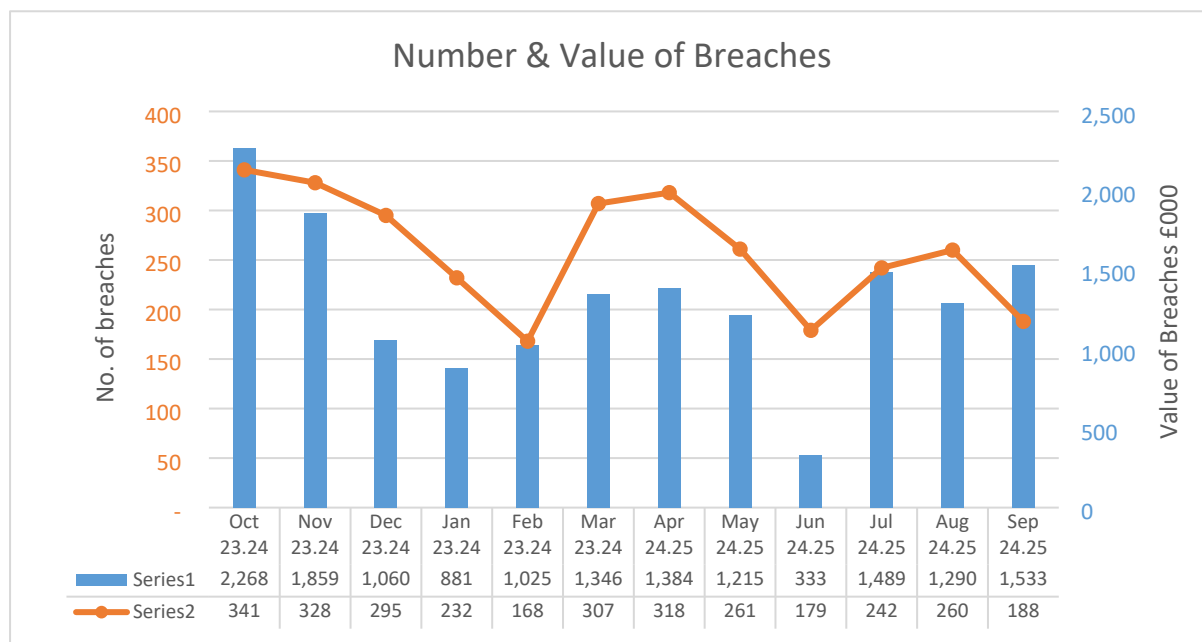
\*Exemptions apply (see SFIs)

Compliance with the SFIs promotes effective control, value for money and ensures that the Health Board operates in compliance with relevant legislation.

## b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a significant increase in the value of Purchase Order breaches in quarter 2 (Q2), with 690 breaches reported with a value of £4.3m. During the same period last Financial Year, the number of breaches were 1,145 with a value of £6.8m.

The value and number of breaches between October 2023 and September 2024 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q2 are as follows:

| Division                          | Month of Breach | Item Description          | PO Amount £000's |
|-----------------------------------|-----------------|---------------------------|------------------|
| Regional Services                 | Sep-24          | CT AND MRI SERVICES       | 807              |
| Chief Digital Information Officer | Sep-24          | CLINICAL SYSTEMS Q2       | 313              |
| Mental Health & LDS               | Aug-24          | MH PATIENT OOA PLACEMENTS | 250              |
| Mental Health & LDS               | Aug-24          | MH PATIENT OOA PLACEMENTS | 172              |
| Regional Services                 | Jul-24          | Ultrasound Services       | 135              |

The Divisions with the highest number of PO breaches have been listed below (£'000s):

| Division            | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | YTD |
|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| East                | 126    | 157    | 129    | 111    | 62     | 101    | 119    | 86     | 70     | 75     | 86     | 64     | 500 |
| Centre              | 82     | 79     | 67     | 49     | 37     | 68     | 83     | 64     | 39     | 57     | 126    | 40     | 409 |
| West                | 57     | 44     | 35     | 17     | 30     | 43     | 51     | 51     | 40     | 62     | 93     | 40     | 337 |
| Regional Services   | 27     | 79     | 21     | 29     | 14     | 23     | 27     | 38     | 24     | 17     | 36     | 25     | 167 |
| Mental Health & LDS | 11     | 18     | 50     | 23     | 27     | 48     | 27     | 37     | 19     | 26     | 35     | 17     | 161 |

| Areas                  | Q1               | Q2               |
|------------------------|------------------|------------------|
| Pay (Agency, Fees etc) | 448,645          | 271,430          |
| Managed Practices      | 129,987          | 136,041          |
| Non Pay                | 2,353,574        | 3,904,490        |
| <b>Total</b>           | <b>2,932,206</b> | <b>4,311,961</b> |

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An all-Wales initiative to issue a standard financial guidance letter, drafted by NWSSP, setting out the expectation to comply with the requisition and order process was issued by the Executive Director of Finance to all budget managers within BCU, on 3<sup>rd</sup> September 2024.

NHS Wales Shared Services Partnership have finalised and approved the purchase order (PO) exemption list as part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales. The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

In addition, Oracle IProc Refresher training sessions are being rolled out in partnership between NWSSP and the Health Board to ensure a better understanding of the processes. In October 23 c450 staff attended the training sessions; in October 2024 c 460 staff attended the sessions held over 2 days.

NHS Wales Shared Services Partnership and the Health Board are continuously reviewing processes and resolving 'invoices on hold' issues, through the Accounts Payable function.

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme



of Reservation and Delegation (SoRD). This will further improve the information reported to the Audit Committee and will enable improved targeted intervention.

**c) Single Tender Waivers (for items of expenditure above £25,000)**

It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver are:

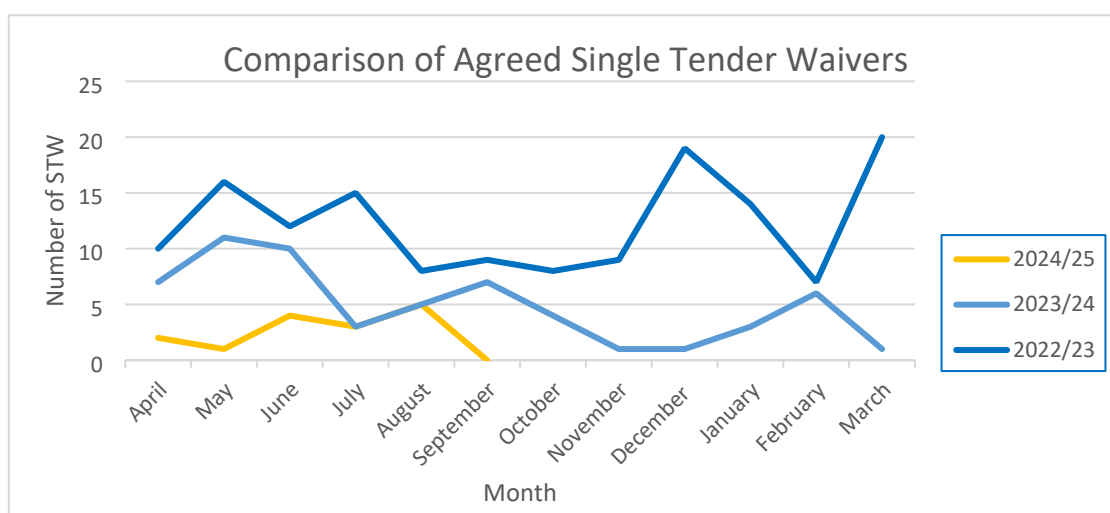
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause;
- A need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

| Single Tender Waivers               | 2023-24 Q2 | 2023-24 FYE | 2024-25 Q2 | 2024-25 YTD |
|-------------------------------------|------------|-------------|------------|-------------|
| Waivers Issued                      | 30         | 100         | 9          | 20          |
| Waivers Approved                    | 15         | 59          | 8          | 15          |
| Value of Approved Waivers           | £0.7m      | £4.5m       | £0.7m      | £1.2m       |
| Waivers approval above EU Threshold | 0          | 8           | 0          | 0           |
| Cancelled Waivers                   | 5          | 13          | 1          | 3           |

The number of approved waivers has significantly reduced in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 1**.



**Single Quote Waivers (for items of expenditure between £5,000 and £25,000)**

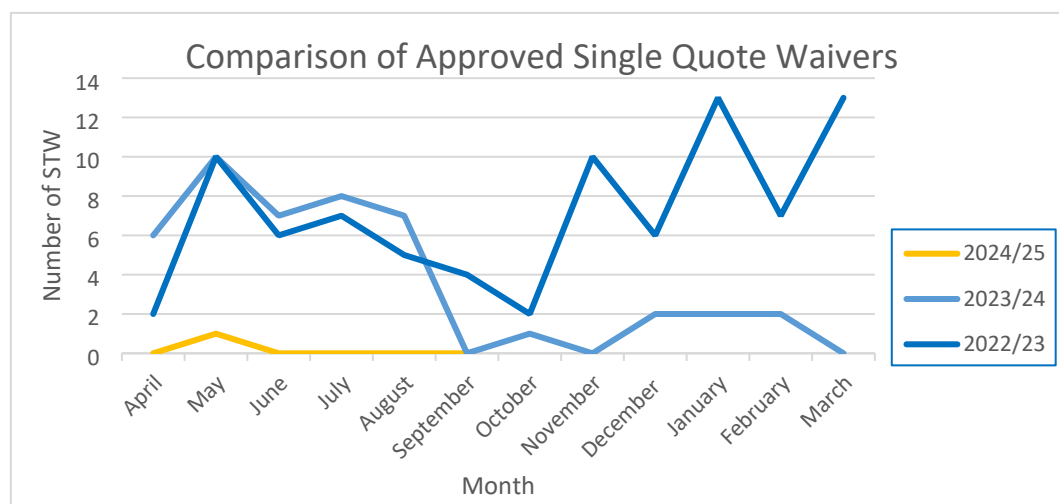
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

| Single Quote Waiver       | 2023-24<br>Q2 | 2023-24<br>FYE | 2024-25<br>Q2 | 2024-25<br>YTD |
|---------------------------|---------------|----------------|---------------|----------------|
| Waivers Issued            | 27            | 94             | 19            | 36             |
| Waivers Approved          | 15            | 45             | 0             | 1              |
| Value of Approved Waivers | £0.16m        | £0.59m         | £0.00m        | £0.07m         |
| Cancelled Waivers         | 6             | 10             | 0             | 0              |

The number of approved waivers has significantly reduced when compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 2**.



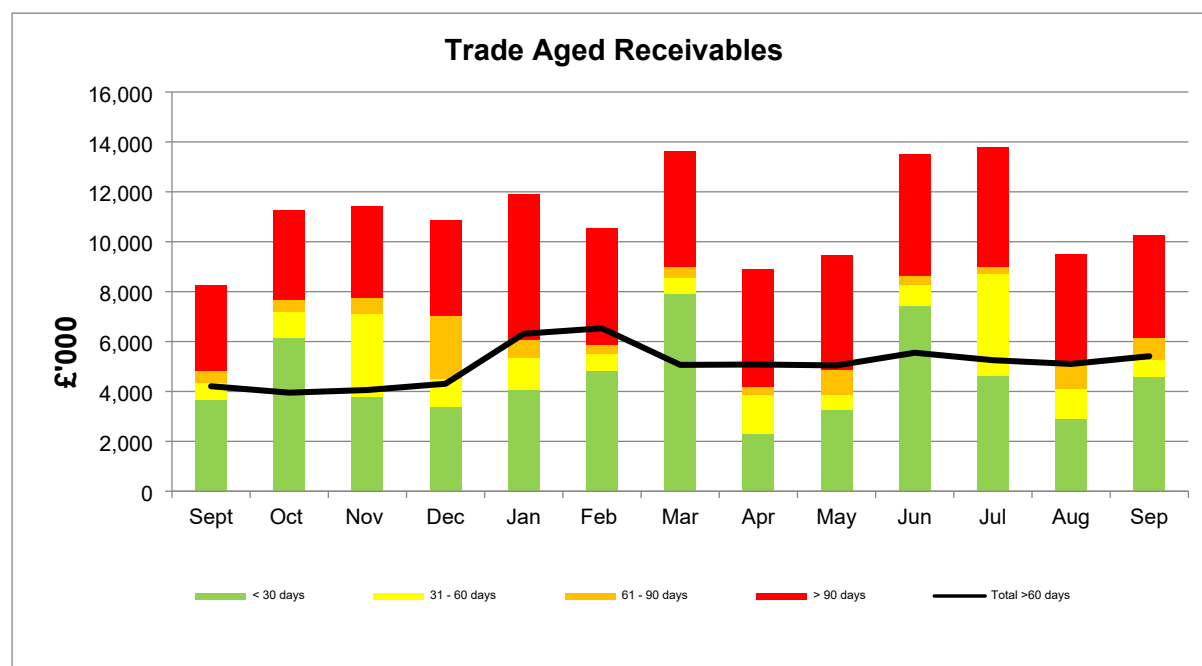
## Section 2 – Receivables and Conformance with Payroll Procedures

### a) Overview of Balances Owed

The Health Board has robust procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30<sup>th</sup> September 2024, there were 3,141 outstanding invoices, totalling £10.2m, of which 628 invoices, totalling £4.6m were less than 30 days old.

The graph below shows the year-to-date trend in total debt and debt profile.



### Provisions for bad and doubtful debts

The Health Board is required to maintain a bad debt provision against each outstanding invoice to cover the any future potential write offs. These provisions are calculated as a percentage of outstanding invoice values and are based on the type and value of each debt as well as historic collectability rates. Invoices are subject to further review on a quarterly basis to assess which bad debt provisions need to be increased to 100% due to specific risk of non-payment. All invoices that have been referred to the Health Board's debt recovery agents are automatically subject to a 100% bad debt provision.

### Receivable balances over £10,000 and in excess of 6 months old as at 30<sup>th</sup> June 2024

The Health Board continues to contact a number of NHS and public sector organisations, escalating aged receivables and to seek specialist recovery advice when required. The table below provides an overview of debts over £10,000 and over 6 months old.

| Customer                                               | £000's | Number of Invoices | Analysis and Further Action                                                                                                                                                                                                                                                                                              | Date Debt Raised  |
|--------------------------------------------------------|--------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| NHS Cheshire and Merseyside ICB                        | 297    | 6                  | All invoices were chased a number of times, all raised queries have been handed over to the Income team who are liaising directly with the NHS Merseyside contact. Meeting was taking place 09/10, awaiting an update.                                                                                                   | Oct 24 and Jan 24 |
| The Walton Centre                                      | 188    | 9                  | All queries were responded to by Income, Walton are refusing to clear these invoices due to another dispute they have with BCU owing them £162k.                                                                                                                                                                         | Apr 22 to Mar 24  |
| St Helens & Knowsley Hospitals NHS Trust               | 97     | 1                  | Invoice is in dispute, currently being looked into by NHS England and the head of the Northwest Lead Employer Deanery. FD followed this up with the Trust 17/10.                                                                                                                                                         | Sep-22            |
| Connahs Quay Primary Resource Centre Management Co LTD | 58     | 1                  | Invoice has been chased several times with payable team, Account Receivable are now liaising with surgery manager for payment date.                                                                                                                                                                                      | Mar-24            |
| Zimmer GmbH                                            | 50     | 1                  | Query now resolved, Invoice has been approved for payment and money should be received withing the next two weeks.                                                                                                                                                                                                       | Mar-24            |
| Salary Overpayment                                     | 46     | 1                  | Debtor refusing to repay invoice until their underpayment resolved. This query is currently with Workforce/Payroll awaiting resolution.                                                                                                                                                                                  | Dec-23            |
| Denbighshire County Council                            | 33     | 2                  | The two Denbighshire invoices were chased a number of times and were placed into dispute by Denbighshire. It was escalated to senior management and is now being chased directly by the service, they have updated Accounts Receivable that 'IFSS posts' were authorised and will look into why they have not been paid. | Mar 20 and Mar 24 |
| Ynys Mon County Council                                | 28     | 1                  | Invoice has been chased a number of times with known contacts within Ynys Mon. Accounts Receivable have requested additional detail from Income to try another contact to prompt a response for payment.                                                                                                                 | Mar-24            |

|                                       |    |   |                                                                                                                                                                                                                                                                                                                                                                                                        |        |
|---------------------------------------|----|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| Overseas Visitor Charge               | 28 | 1 | Debtor with CCI - being chased by the international team in Philippines, trying to locate debtor.                                                                                                                                                                                                                                                                                                      | Sep-22 |
| Salary Overpayment                    | 26 | 1 | Debtor disputing invoice, awaiting response from payroll. Payroll have been chased a number of times for resolution/response. Next step escalate to senior management as no response from payroll.                                                                                                                                                                                                     | Jul-23 |
| NHS South West London ICB             | 22 | 1 | Chased a number of times, various contacts within NHS South West London but no response. Next step is to liaise with Non Contracted Activity team for additional contact details.                                                                                                                                                                                                                      | Jan-23 |
| Overseas Visitor Charge               | 20 | 1 | Debtor with CCI, this case was transferred to the international collection team who are in the process of trying to locate the debtor.                                                                                                                                                                                                                                                                 | Aug-22 |
| Salary Overpayment                    | 20 | 1 | Debtor with CCI, judgement obtained. Debt now with High Court Enforcement Officer to collect payment.                                                                                                                                                                                                                                                                                                  | Mar-20 |
| NHS Greater Manchester ICB            | 17 | 1 | Invoice has been chased, received the following email from Manchester: 'We have been informed not to approve any payments to Wales at the moment as we are awaiting direction from Greater Manchester Safeguarding leadership to ensure we are following the correct process.' This invoice relates to Looked after Children charges, Accounts Receivable trying to establish what the exact query is. | Oct-23 |
| Private Patient Charge                | 16 | 1 | Charge for inpatient treatment, the invoice has been referred to the patient's insurance company and chased several times, due to contracts in place with the insurance company CCI referral is not possible.                                                                                                                                                                                          | Jun-22 |
| NHS Shropshire Telford and Wrekin ICB | 16 | 1 | Invoice was disputed due to query around contract. Income team advised debtor Looked After Children invoices do not form part of a contract so invoice should be released for payment.                                                                                                                                                                                                                 | Oct-23 |
| Salary Overpayment                    | 16 | 1 | Invoice was in query with Workforce for some time, it has now been agreed invoice is payable. Negotiating repayment arrangement with debtor.                                                                                                                                                                                                                                                           | Feb-22 |

|                        |       |     |                                                                                                                                                                                                  |        |
|------------------------|-------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| Boots the Chemist LTD  | 14    | 1   | Chased but no response, Accounts Receivable have obtained more detail and have gone back to contact at Boots that placed order to request urgent payment. Next step if no response, will be CCI. | Feb-24 |
| Salary Overpayment     | 14    | 1   | Debtor with CCI who are proceeding with their collection efforts.                                                                                                                                | Jan-22 |
| Salary Overpayment     | 13    | 1   | The debtor is querying this invoice, payroll are looking into query - Accounts Receivable have chased payroll a number of times for a response. Next step to escalate to senior management.      | Feb-24 |
| Salary Overpayment     | 12    | 1   | Debtor has requested instalment agreement September 24 however, no payments received as yet. Debtor chased and if no response refer to CCI.                                                      | Nov-23 |
| Salary Overpayment     | 10    | 1   | Debtor with CCI, Judgement obtained and collection of payment with High Court Enforcement Officer.                                                                                               | Nov-22 |
| Gwynedd Council        | 10    | 1   | Council said invoice was paid March 24, BCU found not to be the case liaising with Council. Recent contact from Gwynedd to say that they are looking into why this has not been paid.            | Mar-23 |
| Private Patient Charge | 10    | 1   | Charge for inpatient treatment, the invoice has been referred to the patient's insurance company. Accounts Receivable working with insurance to obtain payment.                                  | Oct-20 |
| Q2 Total               | 1,061 | 38  |                                                                                                                                                                                                  |        |
| Q1 Total               | 1,602 | 43  |                                                                                                                                                                                                  |        |
| Movement               | (541) | (5) |                                                                                                                                                                                                  |        |

- *St David's Hospice - Agreed repayment plan over a 3-year period, 1<sup>st</sup> instalment is due 31<sup>st</sup> March 2025*

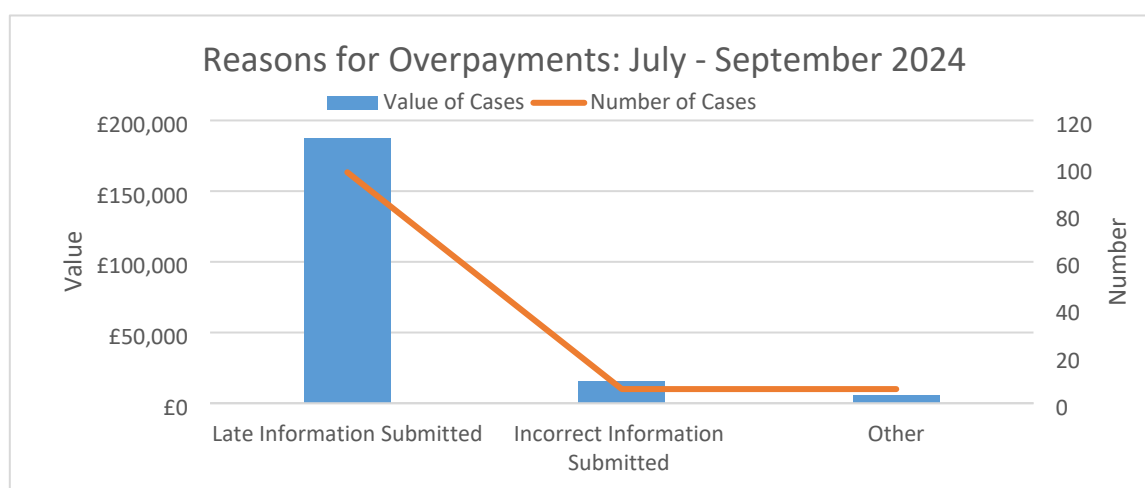
## b) Staff Overpayments

The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected for some time.

|                                      | 2023/24<br>Q2 | 2023/24<br>FYE | 2024/25<br>Q2 | 2024/25<br>FYE |
|--------------------------------------|---------------|----------------|---------------|----------------|
| <b>Number of Salary Overpayments</b> | 117           | 482            | 110           | 273            |
| <b>Value of Salary Overpayments</b>  | £0.338m       | £1.216m        | £0.209m       | £0.622m        |

For the period July to September 2024 there were 110 staff overpayments, with a gross value of £0.209m, comparable to 117 and £0.338m in the previous Financial Year.

Failure to complete forms on time remains the main cause of overpayments. The reasons for the overpayments are detailed below.



The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

In additional staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

It should be noted that overpayments as a result of internal process failures can affect the individuals universal credits, requiring the health board to write of the difference to ensure individuals income are not effected negatively.



### **Staff Overpayment Repayments**

A robust and fair approach in the agreement of repayment periods is adopted to recover amounts as soon as possible; however, this can take a number of months especially where the error is attributed to the Health Board and immediate recovery would cause financial hardship.

As at 30<sup>th</sup> September 2024 the balance outstanding was £1.127m (30<sup>th</sup> June 2024 £1.222m). The debt, by collection stage, is detailed below:

|                                   | <b>No. of Cases</b> | <b>% of Total Outstanding</b> | <b>Value of Total Outstanding</b> |
|-----------------------------------|---------------------|-------------------------------|-----------------------------------|
| <b>Agreed Instalment Plans</b>    | 234                 | 35%                           | £0.327m                           |
| <b>Collection Agents</b>          | 257                 | 38%                           | £0.386m                           |
| <b>In Dispute or Under Review</b> | 10                  | 15%                           | £0.302m                           |
| <b>Reminder Stage</b>             | 51                  | 8%                            | £0.067m                           |
| <b>Invoice Stage</b>              | 31                  | 5%                            | £0.045m                           |

The Health Board expects salary overpayments to be repaid either in a single amount or over the period that the overpayment occurred, with a maximum limit of six months. Where individual circumstances would not make this possible, consideration is given to longer repayment periods following completion of a household income and expenditure account. Repayment plans in excess of six months are reviewed with the debtor on a regular basis.

The extremely aged debts are there because either:

- Former organisations agreed the repayment plans, or
- The HB is bound by legal orders applied on judgement, or
- Senior officers agreed plans over the normal maximum repayment period of 36 months.

NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

### Section 3 - Conformance with Losses and Special Payments Procedures

Losses and special payments should be exceptional in nature and, where they do arise, are subject to additional scrutiny and reporting to the Audit Committee. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

The losses and special payments table below provides an overview of the losses incurred to September 2024. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 306 active claims at the end of September 2024. Of these 128 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £160m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

58% of the caseload (178 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

| Year claim registered | No of claims |
|-----------------------|--------------|
| 2024/25               | 33           |
| 2023/24               | 58           |
| 2022/23               | 51           |
| 2021/22               | 47           |
| 2020/21               | 43           |
| 2019/20               | 34           |
| 2018/19               | 18           |
| 2017/18               | 6            |
| 2016/17               | 3            |
| 2015/16               | 3            |
| 2014/15               | 3            |
| 2013/14               | 1            |
| 2011/12               | 2            |
| 2010/11               | 1            |
| 2009/10               | 2            |
| 2008/09               | 1            |
| <b>Total claims</b>   | <b>306</b>   |

## Losses and Special Payments

|                                                 | Q3 23/24<br>£ | Q4 23/24<br>£ | Q1 24/25<br>£ | Q2 24/25<br>£ | Latest quarter analysis and further action                                                                                                                                                                                                                           |
|-------------------------------------------------|---------------|---------------|---------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medical Negligence                              |               |               |               |               |                                                                                                                                                                                                                                                                      |
| Gross cost                                      | 6,256,148     | 9,541,733     | 4,446,078     | 4,811,287     | Payments were made on 129 cases, of which 30 came under the Redress Scheme.                                                                                                                                                                                          |
| WRPS Reclaim                                    | (5,697,060)   | (9,150,159)   | (3,989,599)   | (4,260,545)   |                                                                                                                                                                                                                                                                      |
| Net Cost                                        | 568,088       | 390,888       | 456,479       | 550,742       |                                                                                                                                                                                                                                                                      |
| Personal Injury                                 |               |               |               |               |                                                                                                                                                                                                                                                                      |
| Gross cost                                      | 140,383       | 77,848        | 53,115        | 81,719        | Payments were made on 48 cases.                                                                                                                                                                                                                                      |
| WRPS Reclaim                                    | (31,375)      | (16,306)      | (406)         | (984)         |                                                                                                                                                                                                                                                                      |
| Net cost                                        | 109,008       | 61,541        | 52,709        | 80,195        |                                                                                                                                                                                                                                                                      |
| Loss of cash                                    | 570           | 0             | 165           | 0             | No loss of cash was reported in Q2                                                                                                                                                                                                                                   |
| Debtors written off                             | 0             | 15,009        | 0             | 41,440        | Debtors are only written off as a last resort, after all means of collection have been exhausted.                                                                                                                                                                    |
| Loss or damage to equipment, property and stock | 48,881        | 104,529       | 67,606        | 55,447        | Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. |
| Ex-gratia payments                              | 17,437        | 19,259        | 43,493        | 20,156        | Relates to 11 payments for loss/damage of patient’s property, 2 payments for ex-gratia payments and 4 ombudsman payments for delayed and unsatisfactory treatment.                                                                                                   |
| VERS Payments                                   | 59,295        | 8,775         | 0             | 0             | All payments are approved by the RATS Committee.                                                                                                                                                                                                                     |
| Total                                           | 803,279       | 600,001       | 620,452       | 747,980       |                                                                                                                                                                                                                                                                      |

\* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000

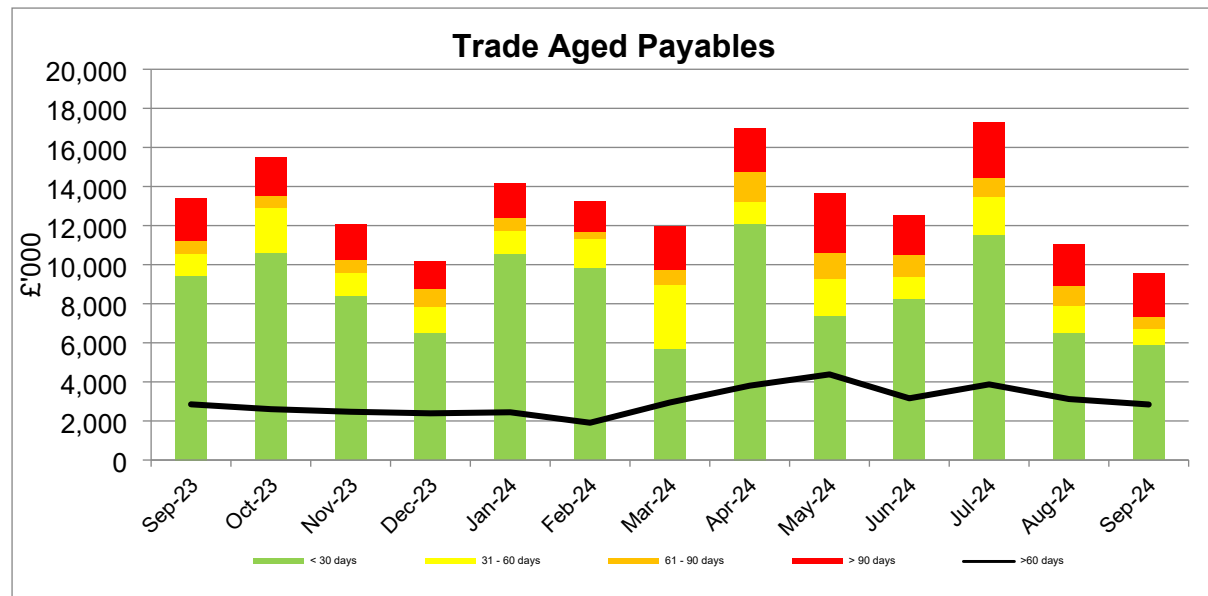
## Section 4 - Conformance with Payable Procedures

### PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year to date achievement for non-NHS invoices by number is 96%.

### High Value (£10,000 plus) Exceptions

The chart below provides an analysis of the trade payables by month.



The high-value (£10,000 plus) exceptions, over 6 months old, are listed in the table below. High value invoices are reviewed on a monthly basis and action is taken to resolve the disputes/queries.

**Payable balances over 6 months old and over £10,000 as at 30<sup>th</sup> September 2024**

| <b>Supplier</b>               | <b>£000's</b> | <b>No of Invoices</b> | <b>Analysis and further action</b>                                                                                                                                                                          | <b>Invoice Date</b> |
|-------------------------------|---------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| Linea Partners Ltd            | 245           | 12                    | Invoices have been formally disputed with the company, the Health Board has sought legal advice.                                                                                                            | Jul - Oct 23        |
| RMS Imaging Ltd               | 42            | 2                     | Copy invoices sent to approver to see if PO has been raised as previous PO fully utilised.                                                                                                                  | Feb & Mar 24        |
| Medtronic Ltd                 | 35            | 2                     | PO quoted has been fully billed, requisitioner contacted to confirm if goods were received and if they were returned.                                                                                       | Mar 23 & Jan 24     |
| Ontex Healthcare UK Ltd       | 29            | 1                     | Not enough value left on PO, department chased as requisitioner no longer works for BCU.                                                                                                                    | Feb 24              |
| Johnson & Johnson Medical Ltd | 24            | 1                     | Supplier appears to have invoiced twice for the same order, a credit has been requested.                                                                                                                    | Dec 22              |
| Flintshire County Council     | 13            | 1                     | Not enough value on PO, requester chased for new PO.                                                                                                                                                        | Mar-24              |
| Becton Dickson UK Ltd         | 12            | 1                     | Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company are unable to provide PoD due to the length of time. Refer to management for advice. | Sep 22              |

**Appendix 1 - Approved Single Tender Waivers >£25K between 1<sup>st</sup> July – 30<sup>th</sup> September 2024**

| Ref No.        | Date of Financial Approval | Area                                      | Name of Supplier                        | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Rationale                      | Value      | Supported By Procurement | Procurement Advice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Breached OJEU |
|----------------|----------------------------|-------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
|                |                            |                                           |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                | £000s      |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |
| 2024/2025-1464 | 09/07/2024                 | Secondary Care - Managed Clinical Support | J F HUNT POWER LTD / J F HUNT FUELS LTD | Hire of a Specialist High Energy Power Generator and fuel deliveries - to power the mobile PET-CT scanning unit. After Covid crisis - the generator use / hire was extended due to the need to provide additional MRI scanning capacity on a mobile unit as well. The generator is required ongoing to power the displaced PET-Scanner - this service is crucial as part of a 10 day Cancer Scanning pathway commissioned nationally by JCC (formerly WHSSC) - (BCUHB being the North Wales provider). A separate business case is being made in parallel to seek capital to provide a fixed power point from the mains supply at YGC - but this will require a relocation also of the service from YMW to YGC - due to not having sufficient power available in the mains system at the Maelor. The generator supplied is specialist in nature - and works well - we are seeking to extend the use by not having to Tender - the current supplier is a national market leader in specialist generators - and most likely only suitable supplier based on the previous waiver / quotes received during end of the Covid period. | Follow on from previous waiver | £96,096.95 | Accept                   | <p>Procurement support this waiver on the basis that it is a continuation of an existing requirement previously waived (2023/2024-1258).</p> <p>Procurement accept not running any additional quotation process at this time due to the likely associated costs and risk of disruption to service whilst the generator is swapped over to a different supplier.</p> <p>Procurement understand conversations are ongoing internally to seek capital funding for a permanent solution to make this requirement redundant eventually.</p> | No            |

|                |            |                                           |            |                                                                                                                                                                                                                                 |                                                                        |            |        |                                                                                                                                                                                                                                                                                                                                                                                                 |    |
|----------------|------------|-------------------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2024/2025-1465 | 19/08/2024 | IHC East (Secondary Care - YWM)           | Checkit    | Annual subscription fee for temperature monitoring at Glan Clwyd, Wrexham Maelor, Gwynedd, Abergel and Llandudno pharmacy sites (each site will raise a requisition, Shared Services requested that only one waiver was raised) | Genuinely one provider                                                 | £37,841.23 | Accept | Waiver supported to the Contract Renewal of service, calibration and monitoring support for Checkit temperature monitoring equipment for Pharmacy. Checkit are the OEM and the only contractor who have the necessary skills, expertise & knowledge to deliver this contract. No other contractor can maintain Checkit's systems, Category Manager, Sourcing Maintenance Team 21st August 2024. | No |
| 2024/2025-1466 | 14/08/2024 | Secondary Care - Managed Clinical Support | Circle Cvi | Cardiac MRI Advanced Visualisation Software                                                                                                                                                                                     | Compatibility Issue (e.g. warranty cover clause or specific equipment) | £33,904.80 | Accept | Procurement services confirm Circle CVI is the sole supplier of this vital clinical reporting software. Department is looking to renew the licensing required to continue using this key software for a three year term.<br><br>Procurement Services support this waiver based upon the sole supplier nature of this requirement, 22/082024                                                     | No |



|                |            |                                           |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |             |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |    |
|----------------|------------|-------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2024/2025-1467 | 10/07/2024 | Estates and Facilities                    | Static Systems Group          | <p>This STW request is a follow up for the existing waiver issued (STW 2021/2022-714). Quotation 418994E Rev 2 Evo2 Upgrade Full Zonal Interfacing had not been identified by the supplier initially, therefore it was impossible for Estates to know and foresee this additional cost. This work is critical as it's enables the existing fire alarm system to interface with the new fire alarm system during the installation period of circa 8 months. This will ensure a resilient system which provides essential fire information to the main fire alarm panel which is vital.</p> <p>418994C Rev 4 - Upgrade to Evo 2 - £347,225<br/> 418994D Rev 2 - Surveys, L1 Design &amp; CAD Drawings, Test and Commission - £33,000<br/> 418994E Rev 2 Evo2 Upgrade Full Zonal Interfacing - £151,213<br/> 418994G Rev 1 Fire Alarm Modifications - Remaining 10% of Evo 2 Network Cabling - £9,525<br/> Contingency - £40,000</p> | Follow on from previous waiver     | £250,690.00 | Accept | <p>Procurement support this waiver. Due to the closed protocol nature of the existing system, there is no option to go to further competition. As such, the initial requirement was actioned via a Single Tender Waiver (2021/2022-714).</p> <p>Following this initial process, additional and unforeseen works are now required and Procurement are satisfied the same sole supplier status is still applicable.</p> <p>Due to the overall value of both waivers, Procurement have completed a Contract Ratification Paper and this has subsequently been approved on the 19th of July by NWSSP's Director of Procurement</p> | No |
| 2024/2025-1469 | 17/07/2024 | Secondary Care - Managed Clinical Support | Beckman Coulter Life Sciences | <p>Extension of 6 months to current lease and reagent purchase agreement required to support service during implementation of new equipment. Tender BCU-OJEU-46049 has been awarded and this is an interim arrangement until deployment. Full justification and timeline including contract award process is detailed in attached SBAR.</p> <p>Total cost covers allowance for reagent purchase in addition to lease component (£25k lease allowance, £90k reagent purchase)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Interim arrangement pending tender | £115,000.00 | Accept | <p>Procurement support the use of a waiver as an appropriate route to market in this instance. A new contract has been awarded to another provider using a competitive tender, however, implementation has been significantly impacted by delays and challenges outside of the Health Board's control I.</p> <p>It is not possible to award this extension via a compliant framework and as any new equipment would need to be validated before use an alternative provider is not practical, therefore a waiver is the appropriate route to market.</p>                                                                       | No |

|                |            |                                   |          |                                                                    |                                                                                                                                                                                                                                                          |            |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |    |
|----------------|------------|-----------------------------------|----------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2024/2025-1475 | 09/08/2024 | IHC East<br>(Area Team<br>- East) | Eschmann | Dental equipment sterilisers -<br>Vacuum Autoclaves 17Lt Type<br>B | Existing contract<br>for maintenance,<br>testing and<br>breakdown repair<br>is with Eschmann,<br>no in house<br>service available.<br>This is more cost<br>effective than<br>having differing<br>separate supplier<br>maintenance<br>contracts in place. | £48,688.00 | Accept | Procurement support this waiver<br>request which enhances the<br>standardisation of equipment across<br>the service. Additionally the current<br>maintenance agreement with<br>Eschmann offers the option of in<br>house services, a more cost effective<br>alternative. Whilst other options have<br>been explored, due to specification<br>challenges they are deemed not<br>suitable for the service. Pursuing an<br>alternative provider would not only<br>incur additional costs e.g. training and<br>would require an additional service<br>contract. | No |
|----------------|------------|-----------------------------------|----------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|

|                |            |                        |                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                   |            |        |                                                                                                                                                                                                                                                                                                                                                                                                                      |    |
|----------------|------------|------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2024/2025-1480 | 22/08/2024 | Estates and Facilities | Applied Power Engineering (APE) (Comap) | Upgrade of highly complex system controllers for the electrical infrastructure at Ysbyty Gwynedd. | <p>Upgrade works of the highly complex Comap controllers that control all the High Voltage critical Vacuum Circuit Breakers for the Electrical Infrastructure at Ysbyty Gwynedd.</p> <p>These critical controllers are now at the end of their operational life and will soon become obsolete with no availability of spares or support. Applied Power Engineering (Comap) are the original system designers.</p> | £92,000.00 | Accept | <p>Procurement support this waiver on the basis of sole supplier due to the complexity of the works. Complex requirement as verified with NWSSP Specialist Estates Principal Electrical Engineer.</p> <p>APE are the original installers, have the in-depth knowledge, technical drawings &amp; documents required to undertake this project without risking delays or complications with alternative providers.</p> | No |
|----------------|------------|------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|

|                |            |                                      |                                    |                                                                                                              |                                    |            |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |    |
|----------------|------------|--------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------|------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2024/2025-1482 | 30/08/2024 | IHC Centre<br>(Secondary Care - YGC) | NANOG<br>Dental<br>Implant<br>Team | To provide diagnostic Cone Beam CT scan for oral, maxillofacial and orthodontic patients requiring CT images | Interim arrangement pending tender | £29,618.00 | Accept | <p>Procurement Services support this waiver request on the basis that Nanog Dental are the sole incumbent supplier of this service in the area at this time. The services provided by this supplier will aide in the reduction of patient waiting lists while a specification and tender pack is created for future procurement activity.</p> <p>- Business Manager 30/08/24</p> <p>It is noted that this is an interim arrangement pending a competitive tender</p> | No |
|----------------|------------|--------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------|------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b><br><b>Report title:</b>                                                                                                                                                                                                                                                                                                                                                                                          | Penalties from the Welsh Risk Pool                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Adrodd i:</b><br><b>Report to:</b>                                                                                                                                                                                                                                                                                                                                                                                                    | Executive Team<br>Audit Committee                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Dyddiad y Cyfarfod:</b><br><b>Date of Meeting:</b>                                                                                                                                                                                                                                                                                                                                                                                    | Audit Committee – 05 November 2024                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Crynodeb Gweithredol:</b><br><b>Executive Summary:</b>                                                                                                                                                                                                                                                                                                                                                                                | This report provides the Executive Team and subsequently the Audit Committee with information on 3 penalties applied by the Welsh Risk Pool (WRP) for late submission of Learning from Events Report forms.                                              |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Argymhellion:</b><br><b>Recommendations:</b>                                                                                                                                                                                                                                                                                                                                                                                          | The meeting is asked to note this report.                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Arweinydd Gweithredol:</b><br><b>Executive Lead:</b>                                                                                                                                                                                                                                                                                                                                                                                  | Pam Wenger, Director of Corporate Governance                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Awdur yr Adroddiad:</b><br><b>Report Author:</b>                                                                                                                                                                                                                                                                                                                                                                                      | Matthew Joyes, Deputy Director for Legal Services                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Pwrpas yr adroddiad:</b><br><b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                 | <b>I'w Nodi</b><br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                              |                                                                                                                                                                                                                                                                     | <b>I Benderfynu arno</b><br><i>For Decision</i><br><input type="checkbox"/>                                                                                                                                                                          |                                                                                                                                                                         | <b>Am sicrwydd</b><br><i>For Assurance</i><br><input type="checkbox"/> |
| <b>Lefel sicrwydd:</b><br><b>Assurance level:</b>                                                                                                                                                                                                                                                                                                                                                                                        | <b>Arwyddocaol</b><br><i>Significant</i><br><input type="checkbox"/><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | <b>Derbyniol</b><br><i>Acceptable</i><br><input type="checkbox"/><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i>           | <b>Rhannol</b><br><i>Partial</i><br><input checked="" type="checkbox"/><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Dim Sicrwydd</b><br><i>No Assurance</i><br><input type="checkbox"/><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br><i>No confidence / evidence in delivery</i> |                                                                        |
| <b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b><br><b>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:</b> |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| Under the delegated arrangements detailed below, the most up to date information on the status and progress of claims is held by the NHS Wales Shared Services Partnership (NWSSP) Legal & Risk Services Department (L&R). Therefore, the information has been extracted from their reports and data and reliance is taken upon that information.                                                                                        |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b><br><b>Link to Strategic Objective(s):</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                          | Objective 1 - Building an effective organisation                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |
| <b>Goblygiadau rheoleiddio a lleol:</b><br><b>Regulatory and legal implications:</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                          | Claims in NHS Wales are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as well as standards set by the Welsh Risk Pool and UK wide requirements for litigation such as the Civil Procedure Rules. |                                                                                                                                                                                                                                                      |                                                                                                                                                                         |                                                                        |

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?<br><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>                                                                                                              | N/A |
| Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?<br><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>                                                                                                               | N/A |
| Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)<br><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i> | N/A |
| Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith<br><i>Financial implications as a result of implementing the recommendations</i>                                                                                                                           | N/A |
| Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith<br><i>Workforce implications as a result of implementing the recommendations</i>                                                                                                                           | N/A |
| Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori<br><i>Feedback, response, and follow up summary following consultation</i>                                                                                                                                           | N/A |
| Cysylltiadau â risgiau BAF:<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><i>Links to BAF risks:</i><br>(or links to the Corporate Risk Register)                                                                                                              | N/A |
| Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)<br><i>Reason for submission of report to confidential board (where relevant)</i>                                                                                                                 | N/A |
| Camau Nesaf: Gweithredu argymhellion<br><i>Next Steps: Implementation of recommendations</i><br>N/A                                                                                                                                                                       |     |
| Rhestr o Atodiadau:<br><i>List of Appendices:</i><br>N/A                                                                                                                                                                                                                  |     |



## INTRODUCTION

This report provides the Executive Team and Audit Committee with information on 3 penalties that have been applied to the Health Board by the Welsh Risk Pool for late submission of Learning from Events Report (LfER) forms.

## 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 WRP is part of the NHS Wales Shared Services Partnership (NWSSP) Legal & Risk Services Department (L&R). It provides the means by which all Health Boards and Trusts in Wales are able to indemnify against risk. The role of the WRP is to have an integrated approach towards risk assessment, claims management, reimbursement and learning.

Health Boards and Trusts in Wales are precluded from procuring commercial insurance for their activities with very limited exceptions. The WRP therefore provides the means by which all Health Boards and Trusts are able to fund their risk exposure for risks such as employers and third party liability, including clinical negligence.

The WRP will reimburse the Health Board for losses incurred above an excess of £25,000. They reserve the right to not reimburse if the WRP Procedures have not been followed or if a claim falls outside of the scope of the indemnity scheme.

WRP operate a detailed set of reimbursement procedures that all organisations must follow in respect of its claims handling and management. They also undertake regular (almost annual) assessments of Health Boards and Trusts in Wales against those procedures and against the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations.

The 2024 assessment has just been completed and findings are awaited. The last completed assessment for the Health Board was finalised in September 2023 with the following assurance ratings:

|                           |                       |  |
|---------------------------|-----------------------|--|
| Redress Case Management   | SUBSTANTIAL ASSURANCE |  |
| Claims Case Management    | REASONABLE ASSURANCE  |  |
| Learning from Events      | LIMITED ASSURANCE     |  |
| WRP Reimbursement Process | SUBSTANTIAL ASSURANCE |  |

To ensure that learning and improvement is commenced and implemented at the earliest possible stage, the WRP has reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case.



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 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 with embedded evidence, expert reports and review findings are appended to the LfER to evidence the learning activity.

**The WRP levies penalties at its discretion for delayed submissions with a range from £2,500 to £25,000 per case. The application of these penalties commenced in 2023.**

The Health Board has recurring issues with the timeliness of Learning from Events Report submissions, with these often delayed within services struggling to find evidence of learning and sustained improvement. In some cases, the internal Legal Services Team have not identified an LfER was due at the correct time resulting in a delay.

In 2023, 4 penalties were levied (at £2,500 each).

At the time of writing, 42 LfERs were overdue of which 1 was with the internal Legal Services Team and the remainder were with services.

As with other backlog areas, such as incidents and complaints, support is being provided to services. The internal Legal Services Team are also looking at how Datix can be used better to ensure trigger events are not missed through human error with some form of safety net (Datix is the national system used to manage cases, developed and managed nationally by the Welsh Risk Pool).

## **SPECIFIC DETAILS**

A summary of the three cases is below:

### **CLA7A1-0408/AMD - W22-489-PI – Personal Injury Claim**

During a data cleanse of the claims data on Datix, it was found that this LfER had not been triggered on the Datix system. The LfER should have been triggered on 27/09/22 and the due date for submission to WRP should have been 20/12/22.

The Legal Services Department sent the LfER to the IHC on 10/01/24. It was agreed that it should be Theatres to progress with the LfER.

The Legal Services Department sent a chaser to the service on 12/03/24.

The LfER was received in the Legal Services Department on 25/03/24. The LfER needed to be signed off and it was sent to the service the following day for signing. On 14/04/24 a chaser was sent requesting that the LfER be returned. The LfER was submitted to WRP on 18/04/24.

### **CLA7A1-0399/JO - W22-1294-PI: Personal Injury Claim**

During a data cleanse of the claims data on Datix, it was found that this LfER had not been triggered on the Datix system. The LfER should have been triggered on 25/04/23 and the due date for submission to WRP should have been 20/07/23.

The LfER was drafted and sent to the service on 28/02/24. A chaser was sent on 22/04/24. The LfER received from the service on 25/04/24 and sent to WRP 26/04/24.

## **CLA7A1-0398/RH - E20-594-CN: Clinical Negligence Claim**

During a data cleanse of the claims data on Datix, it was found that this LFER had not been triggered on the Datix system. On 03/03/23 authority was provided to L&R to serve the Letter of Response making admissions but denying causation. The LFER should have been triggered at this point and the due date for submission to WRP should have been 02/06/23.

The LFER was drafted and sent to the service 22/02/2024.

The LFER was received back from the Service on 02/04/2024 and sent to WRP on 03/04/2024.

### **IMPROVEMENTS**

Following investigation of these cases, and a wider review, there are two main areas affecting the LFER process:

1. LFERs not being triggered by the case manager in the Legal Services Department.
2. LFERs not being completed by services in a timely manner.

In relation to point 1), the Legal Services Department are currently struggling with workloads. This is caused by a number of factors such as an increasing number and complexity of inquests, an increasing number and complexity of claims, new work such as centralisation of Court of Protection cases and delays with internal investigation processes causing significant chasing and monitoring work. The team was formed in 2022, and aligned around the Integrated Health Community model mandated at that time. The model has resulted in inefficiencies with the team essentially working in 4 separate ways (East, Central, West, Regional).

In relation to point 2), services are currently facing backlogs across incidents, investigations, complaints, mortality reviews, etc – so the issue of LFERs is one of many. LFERs can often be triggered several months or years after the incident and repeated changes often mean staff in post within services have limited knowledge of prior events as organisational memory has moved on (this results in obtaining actual evidence difficult). The quality of historic investigations and limited action plan evidence tracking also hinders progress.

In respect of improvements, it is recognised a more fundamental shift in claims management and investigation management is needed which will impact on LFER performance. A number of changes are underway as follows:

- The new Integrated Concerns Policy was approved at the Board in July 2024 and is implementing from September 2024. This new policy will provide an improved and integrated approach to incidents, complaints and mortality reviews with improved tacking of action plans and evidence.
- The legal services function is transitioning to the leadership of the Director of Corporate Governance from the Medical Director and this will allow greater focus and oversight of the full legal portfolio and better alignment with the governance agenda.
- Following on from the above, a full refresh of the claims management process will commence with a new legal policy and process to be developed. This will include a revised approach to LFERs and improved oversight.
- Also following the above, the transition will enable a full refresh of the legal services policies and procedures and ways of working, including how the Health Board maximises the support from NHS Wales Legal and Risk Services.

A further paper will be coming to the Executive Team and the Board shortly outlining the changes around legal services.

## **CONCLUSION AND RECOMMENDATION(S)**

This paper aims to provides a short update on 3 penalties that have been applied to the Health Board by the Welsh Risk Pool for late submission of Learning from Events Report (LfER) forms. It also provides a short update on the changes planned within legal services and to the oversight of LFERs to improve the position.

The Executive Team and Audit Committee are asked to note this report and to note the planned changes and improvements.



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| <b>Teitl adroddiad:</b>                                       | Internal Audit Progress Report 13 August – 16 October 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Report title:</b>                                          | Internal Audit Plan 2024/25 – October 2024 to March 2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Adrodd i:</b>                                              | Audit Committee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Report to:</b>                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Dyddiad y Cyfarfod:</b>                                    | 5 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Date of Meeting:</b>                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Crynodeb Gweithredol:</b><br><br><b>Executive Summary:</b> | <p><u>Progress report</u></p> <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none"><li>the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management.</li><li>the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.</li></ul> <p>New Global Internal Audit Standards are being introduced from January 2025, applicable to the Public Sector from 1 April 2025. We have provided an update on their introduction and any likely impact.</p> <p>We have introduced a new report template from 1 October 2024 which has been rolled out and used at all NHS Wales organisations – changes have been made to how we report findings and agree management response (Appendix 4).</p> <p>The progress report summarises four assurance reviews finalised since the last Committee meeting in September 2024, with the recorded assurance as follows:</p> <ul style="list-style-type: none"><li>Reasonable assurance (yellow) – two</li><li>Limited assurance (amber) – two</li></ul> <p>The report also includes reviews with reports issued as draft and work in progress with details of follow-up of agreed recommendations completed in the period.</p> <p><u>Internal Audit Plan</u></p> <p>The audit plan for 2024/25 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.</p> <p>The internal audit plan for October 2024 to March 2025 details the risk based planned reviews for the second six months of the financial year following review of Board and Committee papers, meeting with the Accountable Officer, and original risks areas identified as part of the April to September 2024 six-month plan.</p> <p>As part of the 2025/26 planning cycle, we will take the opportunity to review the efficacy of the six-month planning approach with the Audit Committee Chair; Accountable Officer; and Director of Corporate Governance in January 2025 as we look to the 2025/2026 financial year.</p> |
| <b>Argymhellion:</b><br><br><b>Recommendations:</b>           | <p>The Committee is asked to:</p> <p><b>Progress Report:</b></p> <ul style="list-style-type: none"><li>Receive the progress report.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li>Note the introduction of the Global Internal Audit Standards from January 2025 with implementation in the Public Sector from 1 April 2025.</li> <li>Note the change in the internal audit report template.</li> </ul> <b>Plan</b> <ul style="list-style-type: none"> <li>Approve the Internal Audit Plan 2024/25 – October 2024 to March 2025.</li> </ul>                                                                                     |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Arweinydd Gweithredol:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Director of Corporate Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Executive Lead:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Awdur yr Adroddiad:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Dave Harries, Head of Internal Audit, CMIIA, QiCA<br>Nicola Jones, Deputy Head of Internal Audit, CMIIA                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Report Author:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Pwrpas yr adroddiad:</b><br><b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | I'w Nodi<br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 | I Benderfynu arno<br><i>For Decision</i><br><input checked="" type="checkbox"/>                                                                                                                                                                       |                                                                                                                                                                                                                                       | Am sicrwydd<br><i>For Assurance</i><br><input checked="" type="checkbox"/>                                                                                          |
| <b>Lefel sicrwydd:</b><br><b>Assurance level:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Arwyddocaol</b><br><i>Significant</i><br><input type="checkbox"/><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>                                                                                                                                                                                                                                 | <b>Derbyniol</b><br><i>Acceptable</i><br><input type="checkbox"/><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Rhannol</b><br><i>Partial</i><br><input type="checkbox"/><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Dim Sicrwydd</b><br><i>No Assurance</i><br><input type="checkbox"/><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><i>No confidence / evidence in delivery</i> |
| <b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b><br><br><b><i>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:</i></b><br><br>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.<br>The Health Board assurance ratings differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | N/A other than those relating to individual audit reviews / recommendations.                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Link to Strategic Objective(s):</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Goblygiadau rheoleiddio a lleol:</b><br><b>Regulatory and legal implications:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b><br><br><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | The Equality duty is not applicable.<br><br>This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).<br><br>The audit plan for 2024/25 is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |
| <b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | The Socio-Economic duty is not applicable.                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                     |

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>                                                                                                                                                                                                                                                                                                            | This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise). |
| <b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b><br><br><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b>                                                                                                            | N/A other than those relating to individual audit reviews/recommendations.                                                                                                                                                                                                      |
| <b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b><br><br><b><i>Financial implications as a result of implementing the recommendations</i></b>                                                                                                                                                                                                                                      | The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.                                                                                                                                    |
| <b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b><br><br><b><i>Workforce implications as a result of implementing the recommendations</i></b>                                                                                                                                                                                                                                      | N/A other than those relating to individual audit reviews/recommendations.                                                                                                                                                                                                      |
| <b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b><br><br><b><i>Feedback, response, and follow up summary following consultation</i></b>                                                                                                                                                                                                                                                      | The progress report is produced independently of management.<br><br>Progress report shared with the Director of Corporate Governance.<br><br>The draft plan has been shared with the Accountable Officer; and Executive Team via the Director of Corporate Governance.          |
| <b>Cysylltiadau â risgiau BAF:</b><br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br><b><i>Links to BAF risks:</i></b><br>(or links to the Corporate Risk Register)                                                                                                                                                                                                                         | N/A other than those relating to individual audit reviews.                                                                                                                                                                                                                      |
| <b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b><br><br><b><i>Reason for submission of report to confidential board (where relevant)</i></b>                                                                                                                                                                                                                            | N/A                                                                                                                                                                                                                                                                             |
| <b>Camau Nesaf:</b><br><b>Gweithredu argymhellion</b><br><br><b><i>Next Steps:</i></b><br><b><i>Implementation of recommendations</i></b><br><br>The progress report and plan are presented according to the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.                                                                                |                                                                                                                                                                                                                                                                                 |
| <b>Rhestr o Atodiadau:</b><br><br><b><i>List of Appendices:</i></b> <ul style="list-style-type: none"> <li>• Appendix 1: Progress report</li> <li>• Appendix 2: Orthopaedic Surgical Hub – Llandudno Hospital report</li> <li>• Appendix 3: Corporate Legislative Compliance – Fire Safety report</li> <li>• Appendix 4: Revised internal audit reporting template effective 1 October 2024</li> </ul> |                                                                                                                                                                                                                                                                                 |

- Appendix 5: BCUHB Audit Plan October 2024 – March 2025



Betsi Cadwaladr University Local Health Board

# Audit Committee Internal Audit Progress Report

13 August to 16 October 2024

NWSSP Audit and Assurance Services

## 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 Chartered Institute of Public Finance & Accountancy in April 2023.

### 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.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal control and the prevention and detection of fraud and other irregularities rests with Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system. This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

## 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) Plans for 2024/25.

## Global Internal Audit Standards

2. In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.

We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.

At this point we do not anticipate there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.

We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

## Reporting template

3. As part of the Audit & Assurance Division's IMTP objectives for 2024/25, one objective focused on our reporting process/template as we recognised changes in reporting format across the public sector, which included reviewing Welsh Government Internal Audit's new template. Following a period of review and consideration in the Division, a new template has been agreed, which ensures compliance with both the current Public Sector Internal Audit Standards (PSIAS) and Global Internal Audit Standards being implemented from January 2025 (replacing the PSIAS from 1 April 2025).
4. This template will be operational across all NHS Wales organisations from 1 October 2024 at the same time (reports currently being developed for reviews will be in the current format). There may be instances where this template may not be appropriate e.g. Special Measures Procurement/Major capital scheme reviews and we will adapt our report accordingly.
5. The key changes are summarised below, with a copy of the template attached at Appendix 4 of the papers:
  - Report layout is now landscape.
  - Reasonable assurance is now a lighter green assurance rating instead of yellow.
  - Low risk recommendation has been removed and any opportunities for enhancement, that do not impact internal control, noted to management as part of debrief meetings/correspondence.
  - Executive Summary has expanded to capture key narrative for first glance of the

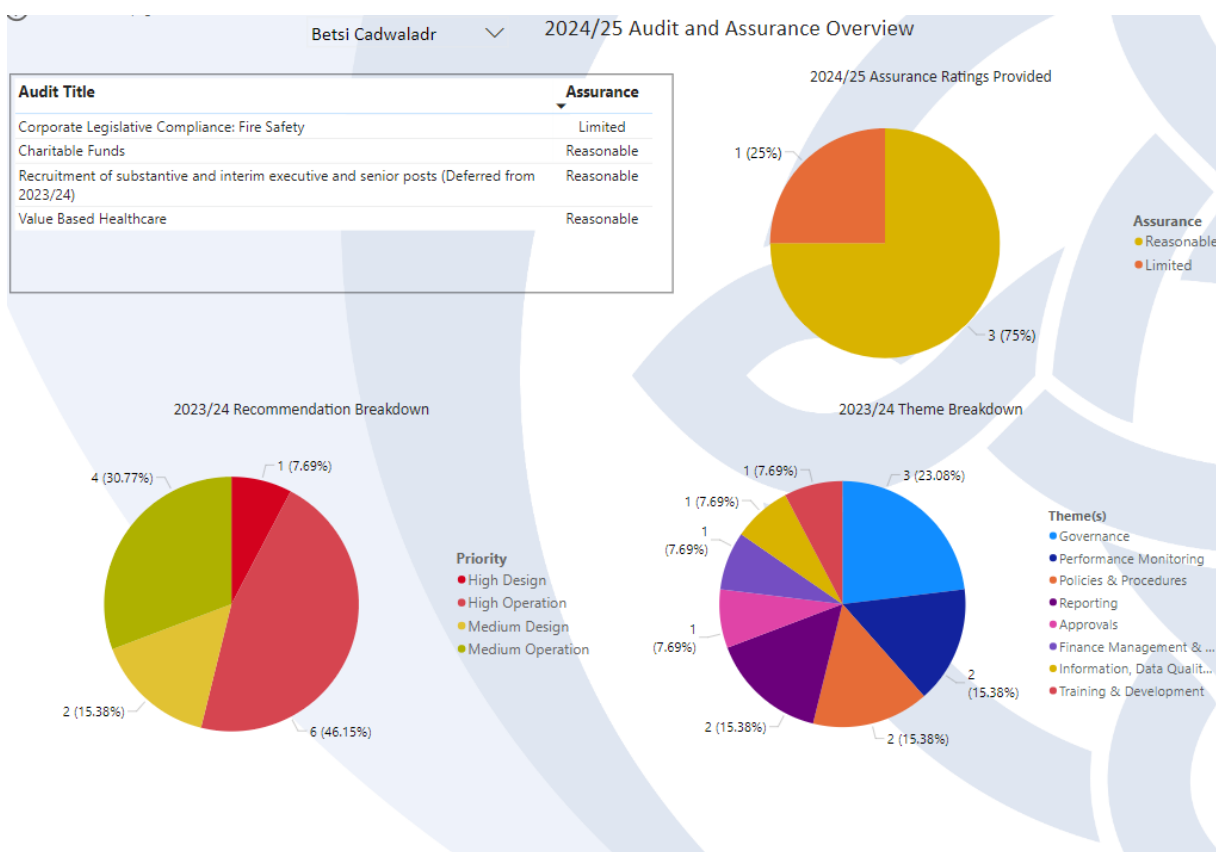
key matters from the review.

- Included a page in the Executive Summary to capture any key metrics identified from data analysis identified as part of the review (this is optional for the auditor).
- New Findings and Agreed Action Plan section – Includes an overview of the findings by each agreed objective with a key finding but no recommendation section; our approach to agreeing management action has changed where we will meet and agree the management response with the auditee. There is a new section to record what evidence we expect to see to support implementation. We have also added a Theme section which will classify what the key finding relates to and correlates to the Executive Summary page – Summary of Management Actions section.

## Reports Issued

6. Since the last progress report, four reviews have been issued as final. One report (Orthopaedic Surgical Hub - Llandudno Hospital) is from the 2023/24 audit plan.
7. The image below details draft and final reports issued to date for the 2024/25 plan. The summary of themes are from final reports, and do not include draft reports. This shows the key themes of recommendations to date relate to governance, performance monitoring, policies & procedures and reporting.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 16 October 2024 – 2024/25 overview



- Theme definition is included at Table 6.

Executive Summaries

Orthopaedic Surgical Hub –  
Llandudno Hospital

BCU-SSU-2324-02

20 September 2024

Report opinion:

Limited



**Purpose:** To evaluate the progression and delivery of the Orthopaedic Surgical Hub at Llandudno Hospital against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Overview

The project is one element of a wider programme that the University Health Board (UHB) have established to address orthopaedic surgery across the organisation. The following was observed at the time of the current review:

- The construction phase had been delayed due to a number of different factors. At the close of the audit this represented a delayed completion from November 2024 to February 2025 – accordingly, the project would not be completed in line with the original timescales.
- The contractual dispute was also likely to impact on the outturn cost position as key materials had yet to be ordered by the contractor (i.e. until the dispute had been resolved).
- There was a concern that documented formal approvals were not obtained for the letting of the main works contract – although noting that emails provided, demonstrated that dialog took place with the Chief Executive Officer (CEO) and Director of Finance (DoF).
- Noting that the formal approvals above were not observed and that a main contract was not in place, works had commenced on site with £435k already committed against the purchase order. It could be determined that this work was currently progressing at risk.
- The contractor, project manager and cost adviser were not under formal contract, potentially exposing the UHB to risk.

| Objectives |                                 |  |  | Assurance  |
|------------|---------------------------------|--|--|------------|
| 1          | Project Performance             |  |  | Limited    |
| 2          | Project Governance Arrangements |  |  | Limited    |
| 3          | Tender Evaluation               |  |  | Limited    |
| 4          | Financial Management            |  |  | Limited    |
| 5          | Contractual Appointments        |  |  | Limited    |
| 6          | Design                          |  |  | Reasonable |
| 7          | Planning                        |  |  | Reasonable |

| Key Matters Arising |                                       | Objective | Control Design or Operation | Recommendation Priority |
|---------------------|---------------------------------------|-----------|-----------------------------|-------------------------|
| 1.2                 | Project Delays                        | 1         | Operation                   | High                    |
| 2.1-2.3             | Minutes and reporting at key meetings | 2         | Design                      | Medium                  |

|         |                                         |   |           |        |
|---------|-----------------------------------------|---|-----------|--------|
| 3.1     | Update of Project Execution Plan        | 2 | Operation | Medium |
| 4.1-4.4 | Main Works Tender Approval Process      | 3 | Operation | High   |
| 4.5-4.6 | Mains Works Tender Approval Process     | 3 | Operation | Medium |
| 5.1     | Project Bank Account                    | 4 | Design    | High   |
| 6.1     | Project Reporting                       | 4 | Operation | High   |
| 7.1,7.3 | Appointment of the UHB's Advisers       | 5 | Design    | High   |
| 7.2,7.4 | Delay in signing of main works contract | 5 | Operation | Medium |

Value Based Healthcare

BCU-2425-07

20 August 2024

Report opinion:

Reasonable



**Purpose:** To review the outcomes related to the Health Board investment of £3.1m in 2023/24 in Value Based Healthcare, including the Value Based Care Function, as detailed in the Financial Plan approved by the Board.

### Overview

The matters requiring management attention include:

- Value Based Healthcare is not reported into existing organisation accountability and reporting frameworks.
- There is presently no oversight via the Health Boards committees in place to monitor VBHC's progress within the Health Board.

### Objectives

### Assurance

|   |                                                                                                                                      |             |
|---|--------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 1 | The funding provided to the Health Board has been allocated and used appropriately to progress value- based health care initiatives. | Substantial |
| 2 | There is progress in implementing value- based healthcare across the Health Board.                                                   | Reasonable  |
| 3 | There is effective oversight of initiatives and reporting to the Board, via it's Committees.                                         | Limited     |
| 4 | The future direction and plans for the Health Board in relation to value- based healthcare are in line with national requirements.   | Not rated   |

### Key Matters Arising

### Objective

### Control Design or Operation

### Recommendation Priority

|   |                                                                                                                           |   |           |      |
|---|---------------------------------------------------------------------------------------------------------------------------|---|-----------|------|
| 1 | An appropriate reporting structure which monitors the progress of VBHC within the Health Board is not currently in place. | 3 | Operation | High |
|---|---------------------------------------------------------------------------------------------------------------------------|---|-----------|------|

Recruitment of substantive and interim executive and senior posts

BCU-2425-14

5 September 2024

Report opinion:

Reasonable



**Purpose:** To assess implementation of both the management actions agreed to because of the limited assurance review in 2022/23 and the independent report commissioned under special measures.

## Overview

Overall, we have seen improvement in compliance with both Welsh Government and the Health Board's own procedure.

The key matters requiring management attention are:

- The Health Board is not formally approving the appointment at Board for all Executive and other Board level Director posts in line with its own governing documents and NHS Wales Regulations (Statute). We recognise the appointments process have complied with expected controls and are considered at Remuneration Committee where all Independent Members are Members.
- The Remuneration Committee has been asked on several occasions to consider additional allowances to Officers following their appointment, with some job descriptions omitting the JESP salary. We recognise this is a risk area that has been identified by People & OD and believe this requires immediate focus to ensure the Health Board delivers value for money in all its appointments and requests for additional allowances do not become a usual agenda item for the Committee.
- There is a conflict between the local Schemes of Reservation and Delegation and Procedure *WP1E Recruitment to Very Senior Posts* that requires review concerning the submission of electronic documentation to NWSSP Payroll Services by the Strategic Recruitment Team.
- There continues to be issues of compliance with the *No Purchase Order, No Pay* requirement of the Standing Financial Instructions concerning Agency interim appointments and payments.

## Objectives

## Assurance

1 The engagement and approval of appointments on Job Evaluation for Senior Posts (JESP) pay scales is in line with Welsh Government, Standing Orders and standard operating procedure requirements.

Reasonable

2 The engagement of interim appointments is compliant with Standing Orders and associated governing documents for posts over the equivalent top step point Band 9 £116,475 (2023/24).

Limited

3 The Remuneration Committee is provided with sufficient information on the recruitment of executive and senior posts to enable oversight and compliance with their responsibilities within the Terms of Reference.

Reasonable

4 Recommendations agreed by Health Board management for the independent and internal audit reviews have been implemented and there is evidence to support on-going compliance.

Reasonable



| Key Matters Arising                                                                                                                                                                                                                                                                                                       | Objective | Control Design or Operation | Recommendation Priority |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------|-------------------------|
| 1 The Health Board does not appear compliant with its Standing Orders or NHS Wales Regulations in formally appointing Executive and Board level Directors.                                                                                                                                                                | 1         | Operation                   | High                    |
| 2 The Health Board has agreed additional allowances to salary for which there is no set procedure or guidance, as it sits outside the Welsh Government control and is a delegated matter for the Board.                                                                                                                   | 1         | Design                      | Medium                  |
| 3 There is an internal control conflict concerning Strategic Recruitment Team Officers completing and submitting documentation to NWSSP Payroll Services who are not authorised to do so per respective Schemes of Reservation and Delegation (SoRD) but are permitted per <i>WP1E Recruitment to Very Senior Posts</i> . | 1,2       | Operation                   | Medium                  |
| 4 Mandatory procurement training completion is captured via ESR and the Finance Directorate, through a spreadsheet. All officers with Accountability Agreements do not currently have this specific local procurement training assigned to their mandatory training profile in ESR.                                       | 1         | Operation                   | Medium                  |
| 5 There continues to be issues of compliance with the Health Board's own Standing Financial Instructions concerning No Purchase Order, No Pay.                                                                                                                                                                            | 2         | Operation                   | High                    |
| 6 Committee Member feedback to our questionnaire has confirmed a need to engage with Members on the content of the reports, ensuring the Committee can fulfil its responsibilities set out in the Terms of Reference.                                                                                                     | 3         | Operation                   | Medium                  |

Corporate Legislative  
Compliance: Fire Safety

BCU-2425-16

15 October 2024

Report opinion:

Limited



**Purpose:** To assess compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', which provides practical guidance in the application of statutory regulation in healthcare premises.

### Overview

The significant matters which require management attention include:

- Fire safety reporting and committee structure needs review, some group meetings are not taking place at the required frequency and there is a lack of assurance to the Health Board.
- The Policy for the Management of Fire Safety (ES04) is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements. This is recognised by management.
- The audit identified non-compliance with Mandatory fire training requirements as stated in the Fire Safety policy. This is an operational management responsibility to ensure compliance.
- The report for the last annual management fire audit was submitted outside the recognised timeframe. We have not been able to verify evidence of submission.
- A number of issues were identified through site testing that are non-compliant with the Management of Fire Safety Policy, such as Fire Fighting Equipment (FFE) not being regularly serviced, out of date risk assessments and a lack of regular fire drills and evacuations.

## Objectives

## Assurance

|   |                                                                                                                                                                   |            |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 1 | There are appropriate governance arrangements in place for fire safety.                                                                                           | Limited    |
| 2 | There are appropriate policies and procedures in place that outline requirements of staff and monitoring arrangements, and these have been communicated to staff. | Reasonable |
| 3 | There is effective central monitoring and reporting to ensure compliance with the Health Board's Policy and legislation.                                          | Limited    |
| 4 | There are effective local arrangements in place to manage fire risks.                                                                                             | Limited    |

## Key Matters Arising

## Objective

Control  
Design or  
OperationRecommendation  
Priority

|   |                                                                                                                                                                                                                                                                  |   |           |        |
|---|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|-----------|--------|
| 1 | Fire safety reporting and committee structure requires review as meetings are not taking place at the required frequency, and there is no evidence of assurance on fire safety arrangements to a Committee / strategic group.                                    | 1 | Design    | High   |
| 2 | The Policy for the Management of Fire Safety (ES04) is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements.                                                                        | 2 | Design    | Medium |
| 3 | Several fire risk assessments have passed their due date (red) and in some cases assessments have not been undertaken since 2020 and 2021. This was confirmed during site visits where risk assessments in two sites were not up to date and required reviewing. | 3 | Operation | Medium |
| 4 | The audit identified non-compliance with training requirements stated in the Fire Safety policy.                                                                                                                                                                 | 3 | Operation | High   |

| Key Matters Arising                                                                                                                                             | Objective | Control Design or Operation | Recommendation Priority |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------|-------------------------|
| 5 The report for the last annual management fire audit was submitted outside the recognised timeframe. We have not been able to verify evidence for submission. | 3         | Operation                   | High                    |
| 6 Non-compliance with elements of the Fire Policy were identified through site visits. These are detailed in Appendix C of this report.                         | 4         | Operation                   | High                    |

## Work in Progress Summary

8. The following draft reports have been issued:

Table 1: Draft Reports issued

| Review                        | Status                           | Date draft report issued | Management response due |
|-------------------------------|----------------------------------|--------------------------|-------------------------|
| Intelligence led organisation | Management response is expected. | 10 October 2024          | 8 November 2024         |
| Charitable Funds              | Management response is expected. | 16 October 2024          | 13 November 2024        |

9. The following 2024/25 reviews are currently in progress:

Table 2: Reviews in progress

| Review                        | Draft report due: |
|-------------------------------|-------------------|
| Special Measures              | October 2024      |
| Grievance Management          | November 2024     |
| Establishment Control Process | October 2024      |
| Transformation & Improvement  | November 2024     |
| Job planning                  | November 2024     |
| Job evaluation                | December 2024     |
| Network & Disaster Recovery   | November 2024     |

## Follow Up

10. The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure.
11. We reviewed evidence provided for forty-nine (49) recommendations and actions. The status of these is:
- Twenty (20) are closed, with sufficient evidence provided.
  - Twelve (12) are partially closed, with some evidence provided.

- Seventeen (17) remain outstanding, where there was either no evidence or insufficient evidence provided.

Table 3 notes the recommendations closed and with internal audit comments. The Corporate Governance Directorate will liaise with Executives and managers to request further information for those partially closed or outstanding.

12. Table 3: Recommendations closed

| Review Title                                                            | Audit Tracker Ref. | Recommendation Title                                                                                                                                                                                                                                                                                                                                                                          | Audit Comments                                                                                                                                    |
|-------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 247                | 1.1 Management must ensure all appointments to JESP/VSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders.<br><br>1.2 Management ensure that mandatory procurement training is in place for all Executive Directors and all staff involved in procurement, as required by Welsh Government Chief Executive, NHS Wales.                            | SOP approved and procurement training has been reviewed as part of recent Interim recruitment report, and confirmed training has been undertaken. |
| Data analysis – Triangulation of data                                   | 259                | 2.1a The three Clinical Executive Directors stipulate the minimum quality and safety data sets for regular reporting across the Health Board, with respective Clinical Directors determining the remaining service specific data required.<br>2.1b The Deputy Director of Quality should ensure the minimum quality and safety data sets are consistently used across all IHCs and Divisions. | Quality dashboard in place - happy to close on this basis, however data quality not assessed.                                                     |
| GP Out of Hours                                                         | 284                | 1.1 Management to develop robust written control documents to support operational processes and strengthen governance arrangements.                                                                                                                                                                                                                                                           | GPOOH Peer Review Improvement Group ToR submitted outlining Group purpose, authority, reporting and assurance arrangements etc.                   |
|                                                                         | 285                | 1.2 Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making.                                                                                                     | GPOOH Peer Review Improvement Group ToR submitted outlining Group purpose, authority, reporting and assurance arrangements etc.                   |

| Review Title                      | Audit Tracker Ref. | Recommendation Title                                                                                                                                                                                                                                                                                              | Audit Comments                                                                                                                                                                                                                  |
|-----------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                   | 288                | 3.1 Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.                                                                                                                                                                               | This was a national discrepancy.                                                                                                                                                                                                |
| Falls Management                  | 307                | 4.1c Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.                                                                                                                               | Evidence provided of a new BCUHB baseline Review standards and questions document currently being used in line with update 31/03/24. Questions now include detail specific to the completion of the FBHMA (page9-10)            |
| Delivery of Health Board Savings  | 347                | The Executive review the Terms of Reference of the Executive Delivery Integrated Performance Group to ensure it includes a strong focus on savings to include service change to drive both quality improvement and recurrent financial savings.                                                                   | ToR for EDG reviewed, includes savings delivery by location and themes.                                                                                                                                                         |
|                                   | 522                | 2.1a The Executive Director of Finance ensures all approved VERS applications are acted on in accordance with the requirements of the Remuneration and Terms of Service Committee, with budget and establishment adjusted accordingly                                                                             | Management advised closure as the 24/25 budget setting process will have superseded these issues.                                                                                                                               |
| Deprivation of Liberty Safeguards | 360                | 2.1a (v): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).                                                                                                                                    | Level 3 MCA/DoLS and the 30 minute awareness training package are evidenced within the file.                                                                                                                                    |
| Learning Lessons                  | 638                | 1.1a: Following the above changes, the process that divisions / areas are required to follow, and documentation they need to complete, should be updated in the Putting Things Right policy and / or the Concerns Procedure.<br><br>1.1b The Health Board should consider the development of a 'Learning Lessons' | Management provided screenshots to show that the Quality Dashboard is now live and the action can be closed. They advised that work will continue focused on ensuring data quality from the various systems into the Dashboard. |

| Review Title                                     | Audit Tracker Ref. | Recommendation Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Audit Comments                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                  |                    | framework/policy, which describes the process and procedures to ensure that lessons learned from all types of events are captured in a consistent approach, and there are mechanisms in place to disseminate the learning across the Health Board. The framework should aim to provide staff access to learning from both incidents and complaints.                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                       |
| Mental Health and Learning Disabilities Division | 1218               | 2.1b: To review TOR of the newly established Divisional Ligature Reduction Group, to ensure appropriate membership, meeting frequency and reporting of the group is discussed, agreed and signed off.                                                                                                                                                                                                                                                                                                                               | Divisional Ligature Risk Reduction Group meeting Terms of Reference provided, includes review of assessments.                                                                                                                                                                                                                         |
|                                                  | 1219               | 2.1c MHLDD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.<br><br>The Chair of each MH&LD local Ligature Reduction Group to provide an exception report to the Divisional Ligature Reduction Group, covering the following: <ul style="list-style-type: none"> <li>• annual review status</li> <li>• evidence of monthly review</li> <li>• risk control and mitigation</li> <li>• progress aligned to external review recommendations</li> </ul> | Copies of monthly Divisional Ligature Reduction Group Assurance Reports provided by each area into the monthly Divisional Ligature Risk Reduction Group meeting (May 2024).                                                                                                                                                           |
|                                                  | 1220               | 2.1d MHLDD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.<br><br>The Chair of the Divisional Ligature Reduction Group to provide an exception report to the MH&LD Divisional Service Quality Group (formally MH&LD QSE meeting, Tier 2) and to the MH&LD Senior Leadership Team meeting (formally DSLT Business meeting, Tier 1) to provide                                                                                                     | Minutes within the file from the MHLDD Ligature Risk Reduction Group Report presented on the 18th June 2024 demonstrates reporting of activity from the Monthly MHLDD Ligature Risk Reduction Group this includes updating on ligature risk register, Internal Audit management plan and SLT escalation reporting on ligature issues. |

| Review Title                                                               | Audit Tracker Ref. | Recommendation Title                                                                                                                                                                                                                                                                                                                     | Audit Comments                                                                                                                                                                                                        |
|----------------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            |                    | assurance on key risks and mitigation plans related to high, medium and low risks to ensure all ligature risk assessments remain subject to regular scrutiny.                                                                                                                                                                            |                                                                                                                                                                                                                       |
| Budgetary Control – User access & Delegated limits                         | 1243               | 1.1a: The Health Board reviews with urgency the status of the Scheme of Reservation and Delegation, ensuring all operational delegated limits across all divisions, services and corporate functions are reflected correctly and approved by the respective Executive/Lead Director.                                                     | SFI's and SORD was refreshed, ratified by Audit Committee, and endorsed by the Board in November 2023.                                                                                                                |
|                                                                            | 1244               | 2.1a: The Executive Director of Finance/Nominated deputy reviews the process surrounding the completion, upload and posting of all journals and develops a Standard Operating Procedure. Management could consider retrospective scrutiny via a transaction report for the month, where set criteria is met and reviewed within Finance. | Closed as superseded by recommendation in 2024 budgetary control report                                                                                                                                               |
| Voluntary Early Release Scheme (VER) – May 2022<br>Voluntary Early Release | 660                | 1.1: Executive Directors ensure all steps detailed by the VER Scheme are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.           | VERS update and closure report provided to Remuneration & Terms of Service Committee 01/09/24.<br><br>Includes terms of scheme.                                                                                       |
|                                                                            | 1261               | 1.2: The Executive Director of Finance confirms the calculation of all reported costs/recurrent savings and provides assurance to Committee that the establishment and savings for all posts being removed/downgraded/reinvested savings have been actioned.                                                                             | VERS update and closure report provided to Remuneration & Terms of Service Committee 01/09/24.<br><br>This includes details of ODP plans re knowledge sharing.<br><br><i>Cannot fully confirm without re-testing,</i> |



| Review Title    | Audit Tracker Ref. | Recommendation Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Audit Comments                                                                                                                                                                                                                                                                                           |
|-----------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                 |                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <i>however closed based on current evidence.</i>                                                                                                                                                                                                                                                         |
|                 | 1262               | 1.1: Executive Directors ensure all steps detailed by the VER Scheme are complied with in full, paying particular attention that all Directors/Line Managers provide comprehensive narrative regarding the 'risk from loss of skills and experience/patient safety, quality and safety can be maintained or enhanced' section.<br>1.2: The Executive Director of Finance confirms the calculation of all reported costs/recurrent savings and provides assurance to Committee that the establishment and savings for all posts being removed/downgraded/reinvested savings have been actioned. | VERS update and closure report provided to Remuneration & Terms of Service Committee 01/09/24.<br><br>Report includes recurring saving details, giving totals and amount per individual.<br><br>Includes detail that work has been undertaken within finance / ESR to reflect saving changes in budgets. |
| Risk Management | 1254               | 8: A full review of all risks should be undertaken by operational managers to ensure that all risks are scored correctly and that they have been allocated to the correct Tiers. All reviewed risks should be signed off by the RM department and the risk owner following review.                                                                                                                                                                                                                                                                                                             | Management provided evidence of Risk Management Group Cycle of Business to note this was completed.                                                                                                                                                                                                      |
|                 | 1270               | 1.2: Head of Risk Management to consider the formal review of operational risks registers be undertaken by the Corporate Risk Team on a regular, cyclical basis.                                                                                                                                                                                                                                                                                                                                                                                                                               | Risk Scrutiny Group agenda for October includes a 'Governance Risk Register' report. The detail in the report includes the risk registers that have been audited by the Risk Management Team.                                                                                                            |

### Contingency/Organisational Support/Advice

13. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.
14. We meet with Audit Wales, Healthcare Inspectorate Wales, Health & Safety Executive and Public Services Ombudsman for Wales regularly to discuss recent issues and areas of emerging risks to the Health Board.

### Delivering the Plan

15. The additional support provided to the Health Board with focused reviews is channelled through contingency. As new risks are identified in year, the Director of Corporate Governance and internal audit will consider the planned reviews against the emerging high-level risks.
16. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5).
17. Table 4 is reporting a positive status across two of three indicators. Figures are based on three reports issued as final for 2024/25. We have seen a reduction in management response turnaround times, and this has reduced compliance to amber.

Table 4: 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] | Amber  | 67%    | 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 5: Core Plan 2024-25 (April 2024 to September 2024)

| Planned output                              | Outline timing          | Status                                        | Assurance (including draft report assurance opinions) |
|---------------------------------------------|-------------------------|-----------------------------------------------|-------------------------------------------------------|
| Special Measures                            | June / July 2024        | Review in progress.                           |                                                       |
| Follow-Up of Internal Audit recommendations | April to September 2024 | Completed – reported through progress report. | Not applicable                                        |
| Transformation & Improvement                | August / September 2024 | Review in progress.                           |                                                       |
| Charitable Funds (Deferred from 2023/24)    | June / July 2024        | Draft report issued.                          | Reasonable                                            |
| Value Based Healthcare                      | June / July 2024        | Final report issued.                          | Reasonable                                            |
| Business Cases: Capital                     | July / August 2024      | Review in progress.                           |                                                       |

| Planned output                                                                                                                                                                                                                                                                 | Outline timing             | Status               | Assurance (including draft report assurance opinions) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------|-------------------------------------------------------|
| Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)                                                                                                                                       | July / September 2024      | Planning.            |                                                       |
| Intelligence led organisation                                                                                                                                                                                                                                                  | July 2024                  | Draft report issued. |                                                       |
| Network and Disaster Recovery                                                                                                                                                                                                                                                  | September 2024             | Review in progress.  |                                                       |
| Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)                                                                                                                                                                                      | June / July 2024           | Final report issued. | Reasonable                                            |
| Establishment Control and Recruitment                                                                                                                                                                                                                                          | July / August 2024         | Review in progress.  |                                                       |
| Integrated Assurance and Approval Plans (IAAP) <ul style="list-style-type: none"> <li>Llandudno Hospital Orthopaedic Hub</li> <li>Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit</li> <li>Ysbyty Maelor Wreccsam - Infrastructure/ Continuity Works</li> </ul> | April to September 2024    | Planning.            |                                                       |
| Corporate Legislative Compliance: Fire Safety                                                                                                                                                                                                                                  | May 2024                   | Final report issued. | Limited                                               |
| People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)                                                                                                                                                                                             | June / July 2024           | Deferred.            |                                                       |
| Quality Governance: Concerns and Complaints                                                                                                                                                                                                                                    | July / September 2024      | Deferred.            |                                                       |
| Corporate Legislative Compliance: Civil Contingencies Act 2004                                                                                                                                                                                                                 | June / July 2024           | Deferred.            |                                                       |
| Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)                                                                                                                                                                               | October 2024 to March 2025 | Deferred.            |                                                       |

## 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:

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

Table 6: Themes and definitions relating to Image 1

| Ref. | Theme                      | Definition / Examples                                                                                                                                                                                                                                                                                                                                                                                      |
|------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | Approvals                  | The internal control framework for securing approvals is ineffective.<br>Appropriate approvals have not been sought/ obtained prior to key decisions.                                                                                                                                                                                                                                                      |
| 2    | Communication & Engagement | There is no clear communication strategy and/ or stakeholder identification arrangements.<br>Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders.<br>Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored. |
| 3    | Contractual                | The form of contract is not appropriate and does not adequately protect the interests of the organisation.<br>Contractual documentation has not been executed in a timely manner.<br>The contract is not being applied as intended.                                                                                                                                                                        |
| 4    | Cyber Security             | There is no strategy for maintaining cyber security and/ or it is deficient.<br>The strategy/ plans are not implemented as intended and are therefore ineffective.                                                                                                                                                                                                                                         |

| Ref. | Theme                                    | Definition / Examples                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5    | Financial Management & Control           | Financial controls and management information requirements have not been properly considered.<br>The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.                                                                                                                                                                                                                                                         |
| 6    | Governance                               | Inadequate / ineffective governance and oversight structures in place, which may include: <ul style="list-style-type: none"> <li>• Absence of key roles and associated responsibilities to provide good governance.</li> <li>• Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees.</li> </ul> General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited. |
| 7    | Information & Data Quality / Accuracy    | Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality.<br>There is limited/ no guidance on the expected arrangements for data and information management.<br>Insufficient records are maintained and/ or there are key gaps that would impact decision making.<br>Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.      |
| 8    | Lessons Learnt                           | There are inadequate or no systems and processes in place to capture lessons learnt.<br>Lessons learnt are not regularly shared/ reviewed within the organisation.<br>There is clear evidence that the organisation has not learnt from prior experiences.                                                                                                                                                                                                                        |
| 9    | Performance Monitoring                   | There are no/ limited systems in place to capture performance information.<br>The systems are ineffective in capturing the required information to manage performance.<br>Performance information is not monitored and/ or shared.<br>Corrective action to address performance issues is not determined or is ineffective.                                                                                                                                                        |
| 10   | Physical Security                        | There is no strategy/ plan to maintain physical security.<br>There is a lack of consideration of physical security needs (either current and/or future)                                                                                                                                                                                                                                                                                                                           |
| 11   | Planning, Delivery & Deadline Management | A lack of timescales or deadlines being set.<br>Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.                                                                                                                                                                                                                                                                    |
| 12   | Policies & Procedures                    | There are no policies or procedures in place, or they are inadequate to manage the risk.                                                                                                                                                                                                                                                                                                                                                                                          |

| Ref. | Theme                  | Definition / Examples                                                                                                                                                                                                                                                                                                                                                                            |
|------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      |                        | Policies or procedures are overdue for review or do not reflect current operational and/or best practice.                                                                                                                                                                                                                                                                                        |
| 13   | Reporting              | Reporting and escalation requirements not clearly defined, including what gets reported where and when.<br>Defined reporting does not provide adequate information to support robust assurance, escalation and risk management.<br>Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place. |
| 14   | Resourcing             | Organisational planning and management approaches do not incorporate consideration of demand and capacity.<br>Demand and capacity inadequately considered.<br>Lack of proactive review of resource to deliver plans or business-as-usual activities.                                                                                                                                             |
| 15   | Risk Management        | Inadequate/ ineffective risk strategy, appetite and/or management arrangements.<br>The approach to risk management and/ or arrangements applied are not operating as intended.                                                                                                                                                                                                                   |
| 16   | Strategy               | An appropriate strategy has not been developed to outline the vision of the organisation.<br>The strategy is not an effective tool in achieving organisational objectives.                                                                                                                                                                                                                       |
| 17   | Training & Development | There is no defined strategy for training and development.<br>Training needs have not been identified.<br>There is no plan in place to address identified training needs.                                                                                                                                                                                                                        |

# Orthopaedic Surgical Hub Llandudno Hospital Final Internal Audit Report September 2024

Betsi Cadwaladr University Health Board



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



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board





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|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Review reference:             | BCU_Ssu_2324_02                                                                                                                                                                                                                         |
| Report status:                | Final                                                                                                                                                                                                                                   |
| Fieldwork commencement:       | 9 <sup>th</sup> January 2024                                                                                                                                                                                                            |
| Fieldwork completion:         | 22 <sup>nd</sup> April 2024                                                                                                                                                                                                             |
| Draft report issued:          | 20 <sup>th</sup> May 2024, 24 <sup>th</sup> July 2024                                                                                                                                                                                   |
| Management response received: | 24 <sup>th</sup> May 2024, 19 <sup>th</sup> August 2024, 17 <sup>th</sup> September 2024                                                                                                                                                |
| Final report issued:          | 20 <sup>th</sup> September 2024                                                                                                                                                                                                         |
| Auditors:                     | NWSSP: Audit & Assurance - Specialist Services Unit (SSu)                                                                                                                                                                               |
| Executive sign-off:           | Chris Stockport, Executive Director – Transformation and Strategy (SRO for Project)                                                                                                                                                     |
| Distribution:                 | Nicola Eatherington, Assistant Area Director Intermediate Care Services & Specialist Medicine (Project Director)<br>Daniel Eyre, Head of Capital<br>Ruth Stiles, Senior Project Manager<br>Pam Wenger, Director of Corporate Governance |
| 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 Chartered Institute of Public Finance & Accountancy in April 2023.

### 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.

### 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

The purpose of this audit was to evaluate the progression and delivery of the Orthopaedic Surgical Hub at Llandudno Hospital against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

## Overview

The project is one element of a wider programme that the University Health Board (UHB) have established to address orthopaedic surgery across the organisation.

The following was observed at the time of the current review:

- The construction phase had been delayed due to a number of different factors. At the close of the audit this represented a delayed completion from November 2024 to February 2025 – accordingly, the project would not be completed in line with the original timescales.
- The contractual dispute was also likely to impact on the outturn cost position as key materials had yet to be ordered by the contractor (i.e. until the dispute had been resolved).
- There was a concern that documented formal approvals were not obtained for the letting of the main works contract – although noting that emails provided, demonstrated that dialog took place with the Chief Executive Officer (CEO) and Director of Finance (DoF).
- Noting that the formal approvals above were not observed and that a main contract was not in place, works had commenced on site with £435k already committed against the purchase order. It could be determined that this work was currently progressing at risk.
- The contractor, project manager and cost adviser were not under formal contract, potentially exposing the UHB to risk.

Other recommendations are provided within the detail of the report.

Noting the above, **limited assurance** has been determined.

## Report Classification

Limited



More significant matters require management attention.

**Moderate impact** on residual risk exposure until resolved.

## Assurance summary <sup>1</sup>

| Assurance objectives |                                 | Assurance  |
|----------------------|---------------------------------|------------|
| 1                    | Project Performance             | Limited    |
| 2                    | Project Arrangements Governance | Limited    |
| 3                    | Tender Evaluation               | Limited    |
| 4                    | Financial Management            | Limited    |
| 5                    | Contractual Appointments        | Limited    |
| 6                    | Design                          | Reasonable |
| 7                    | Planning                        | Reasonable |

<sup>1</sup> 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 |
|---------------------|-----------------------------------------|---------------------|-----------------------------|-------------------------|
| 1.1                 | Project Delays                          | 1                   | Operation                   | High                    |
| 2.1 – 2.3           | Minutes and reporting at key meetings   | 2                   | Design                      | Medium                  |
| 3.1                 | Update of Project Execution Plan        | 2                   | Operation                   | Medium                  |
| 4.1-4.4             | Main Works Tender Approval Process      | 3                   | Operation                   | High                    |
| 4.5-4.6             | Main Works Tender Approval Process      | 3                   | Operation                   | Medium                  |
| 5.1                 | Project Bank Account                    | 4                   | Design                      | High                    |
| 6.1                 | Project Reporting                       | 4                   | Operation                   | High                    |
| 7.1,7.3             | Appointment of the UHB's Advisers       | 5                   | Design                      | High                    |
| 7.2, 7.4            | Delay in signing of main works contract | 5                   | Operation                   | Medium                  |

## 1. Introduction

- 1.1 The audit focused on the management arrangements in place to progress the development of an Orthopaedic Surgical Hub at Llandudno Hospital.
- 1.2 The Llandudno Orthopaedic Facilities project was one of several elements of a wider Orthopaedic Programme. This audit focused solely on the delivery of the project but also reviewed any aspects that were overseen at a programme level.
- 1.3 The Business Justification Case (BJC) approved by Welsh Government (WG) sought capital investment of £29.4m to enable the introduction of the Surgical Hub, which was an integral part of Betsi Cadwaladr University Health Board's (BCUHB's) wider plan for transforming elective orthopaedic services. This included £25.543m for the main works and an additional £3.910m for enabling works.
- 1.4 This was the first audit undertaken of the project and it was commissioned in accordance with the agreed provision (and associated funding) provided within the approved BJC.
- 1.5 The potential risks considered at this review included:
  - The project may not be effectively managed;
  - The project over-runs on time and cost; and
  - The failure to achieve the required quality or anticipated benefits.

## 2. Detailed Audit Findings

**Project Performance:** A summary of the achievement of the project's key delivery objectives (time, cost, and quality) for the period. At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the areas under review are suitably designed and applied effectively.

### Background

- 2.1 At this first audit of the Orthopaedic Surgical Hub Project at Llandudno Hospital, when assessing progress against the original delivery objectives, the following was evidenced:

#### Time

- 2.2 The Programme Initiation Document (PID) highlighted that '*there is a ministerial expectation that the project is delivered in year 2024*'.
- 2.3 As at the date of fieldwork, the project had not commenced on site due to a number of factors– which had delayed the formal signing of the main works contract. The original anticipated operational date had been revised forward from November 2024 to a current estimated date (handed over and operational) of 25<sup>th</sup> February 2025. **(MA1.1)**

- 2.4 The enabling works for the project had yet to commence on site, acknowledging that the appointment of the contractor had only been approved by Performance, Finance and Integrated Governance Committee (PFIG) on the 30<sup>th</sup> April 2024.

### Cost

- 2.5 The project funding at the BJC and agreed by Welsh Government was stated as:

**Figure 1: Project Funding**

| Current Funding Position               | (£)               |
|----------------------------------------|-------------------|
| Works Costs (including enabling costs) | 14,130,490        |
| Fees                                   | 1,286,958         |
| Non-Works                              | 341,571           |
| Equipment Costs                        | 3,480,000         |
| Costed risk register allowance         | 2,261,123         |
| Welsh Government Held Contingency      | 3,258,468         |
| VAT (including reclaim)                | 4,694,330         |
| <b>Overall</b>                         | <b>29,452,941</b> |

- 2.6 At the time of the audit, the main contract, whilst not signed, was valued at £9.215m and the enabling works contract was approved in the sum of £5.783m. A paper submitted to the PFIG committee confirmed that the UHB would require release of circa £2.4m of the ringfenced £3.9m that had been retained by Welsh Government in anticipation of enabling works cost inflation. This had been subsequently communicated to WG.
- 2.7 It was anticipated that the delay to the start of the construction stage of the project was likely to further impact the outturn cost – recognising that orders had not been placed by the Main Construction Partner for materials (pending resolution of the noted issues).

### Quality

- 2.8 The UHB appointed its design team through its own local framework.
- 2.9 The UHB reported that user group meetings were to be established (commencing in February 2024) to work through the detailed level of design. However, it was not possible to corroborate that this had been actioned as at the time of audit fieldwork.

### Conclusion

- 2.10 Recognising the desire to deliver an expedited project, the delays experienced to date and the potential future cost implications are sufficient to determine **limited assurance** in respect of project performance.
- 2.11 The following sections of the report further outline the key observations that had contributed to the above – matters which require management attention, with moderate impact on residual risk exposure until resolved.

---

**Project Governance** – *To obtain assurance that appropriate governance arrangements were in place for the current project phase including operation of effective reporting and accountability lines and that appropriate approvals were in place.*

- 2.12 As noted previously, the Llandudno Orthopaedic Facilities project was one of several elements of a wider Orthopaedic Programme. The Senior Responsible Officer (SRO) for the scheme was assigned to the Executive Director of Transformation and Strategy. The SRO was responsible for the successful delivery of the outcomes of the project/programme, accountable to the sponsoring group and chaired the Programme Board.
- 2.13 Similarly, the Programme Director had responsibility for both the overall programme and individual projects.
- 2.14 The overall governance framework for the wider programme was detailed within the PID published on the 10th of January 2024.
- 2.15 The PID itself was a comprehensive document that covered the anticipated areas. However, at the time of audit fieldwork the document was listed as draft and did not detail whether it was formally ratified. It is noted that the PID has since been revised and approved.
- 2.16 The Programme Board met on a fortnightly basis for the period October 2023 to January 2024, with a name change being implemented during January 2024 from Orthopaedic Programme Board to HVLC' Surgical Hub Programme Board. The Programme Board's agenda detailed a standing agenda item on workstream 1a (Llandudno Orthopaedics), however it was not possible to verify the depth of discourse in relation to this due to absence of Programme Board minutes – the only record of the meeting being an action log. This was of particular concern given that the agenda detailed verbal updates on contract/ procurement issues, the delays experienced and contractual issues. Accordingly, there was an absence of an adequate audit trail over key project issues and decisions. **(MA2.1)** Subsequent to fieldwork, it has been confirmed that Programme Board minutes are now formally recorded, however there is a significant period where it was not minuted and key discussions were held.
- 2.17 Management advised that the Project Board, which was to oversee Llandudno Phase 1 and Abergele projects, convened for the first time in February 2024, despite a request, any available agendas and minutes for the Project Board were not provided for review. It is recognised that the recording of Project Board minutes was introduced after the conclusion of audit fieldwork. **(MA2.2 & MA2.3)**
- 2.18 The Project Execution Plan (PEP) dated 2<sup>nd</sup> October 2023 was produced by the UHB's external advisors. The PEP as provided for review was developed for a previous UHB project (as it contained management comments pertaining to a different project) and was incomplete i.e. the governance arrangements omitted details of the Programme Board and Project 'aims and objectives' were left blank with the comments 'to be provided by BCUHB'). **(MA3.1)**
-

2.19 The PEP covered the majority of the sections expected. However, the PEP was not signed or dated and would require updating to reflect the move to the construction stage of the project. **(MA3.1)**.

2.20 Noting issues detailed above, **limited assurance** has been determined in this area.

**Tender Evaluation** - an assessment of the arrangements to determine the value for money for the scheme, along with robust evaluation.

2.21 As noted previously, the project comprised enabling works and a main works package. Both were subject to a full tender process with the support of NWSSP: Procurement Services.

2.22 In respect of the main works, a Contract Award Recommendation Report (CARR) was produced along with a tender evaluation conducted by the UHB's Cost Advisers.

2.23 The tender evaluation undertaken by the Cost Adviser's was shared with the UHB's CEO and DoF in an email dated 13<sup>th</sup> October 2023, this noted that a copy of the CARR would follow for approval.

2.24 The CARR did not detail the following comments from the Cost Advisers report:

- Other works had been excluded from the calculations (£166k from the successful tender).
- Radiation protection and raising of theatre extension floor were omitted from the successful tender and unpriced.
- The costs within the tender submission were generally lower than that of the other tenderers – the Cost Adviser determining this represented a higher risk associated with their tender.

The Cost Adviser did challenge the tender submission by requesting additional evidence to support it, however whilst the resulting Cost Adviser evaluation report concluded that the successful tender was the lowest it did not explicitly address whether Value for Money had been achieved or recommend acceptance of the tender. **(MA4.1)**

The UHB Project Team itself also provided ongoing challenge of the Project Manager and Cost Adviser, although these actions were not documented in the reports.

2.25 The UHB were also supported by NWSSP Specialist Estates when agreeing the costs for the project.

2.26 The enabling works form a part of separate package with a separate contract.

2.27 A CARR was produced specifically for the enabling works package. The following was observed in respect of the document:



- Key concerns raised around the availability and experience of the contractor team highlighted by the evaluators – particularly in relation to High Voltage (HV) and Low Voltage (LV) – remained unaddressed at the report.
- The commercial evaluation was based on divergence from lowest bid – noting there was only one bid, the tenderer scored fully (65 out of 65). The report did not detail how value for money had been demonstrated (e.g. benchmarked against other project costs or against a pre-tender estimate of the costs).
- It did not detail the Cost Adviser concerns highlighted within their evaluation report concerning unsubstantiated and higher than expected costs. **(MA 4.2)**

2.28 Similar to the main works, the Cost Adviser report did not conclude whether the submission demonstrated value for money. **(MA4.1)**

2.29 From the various reports reviewed, it was concluded that the pre-tender estimates could not be used as a reliable benchmark as they were not updated for revised design changes. **(MA 4.5)**

2.30 Noting the above, **limited assurance** has been determined in respect of the tender evaluation processes.

**Financial Management** – *To obtain assurance that appropriate management controls were in place, including approvals, budget setting, financial monitoring/management, use of project bank accounts and ongoing cost monitoring.*

2.31 The project was the subject of a single stage business case, this was presented to the UHB's Board on the 28<sup>th</sup> of September 2023 where the recommended option to develop a single site orthopaedic surgical hub capacity in Llandudno, the associated capital cost (estimated at the time) and revenue requirements were endorsed.

2.32 Whilst the CARR was completed for the main works package. The subsequent approval to appoint the main contractor by the Director of Finance and/ or an appropriate forum was not evidenced. **(MA4.3)**

2.33 Similarly, whilst the CARR was completed for the enabling works, duly signed by the Director of Finance and submitted/ approved by the PFIG Committee on the 30<sup>th</sup> of April 2024; the approval assumed that the UHB would access £2.4m of the £3.9m WG held contingency. However, at the time of concluding the review, the UHB were awaiting confirmation of the same from the WG. **(MA 4.6)**

2.34 To avoid disruption to the programme, an element of "priority works" in the sum of £1.3m had been transferred from the enabling works to the main scheme – to be instructed as a formal contract change. The corresponding approval to reallocate the funding and change the scope of both projects was not evidenced, this coinciding with the period when minutes were not formally recorded for either Programme or Project Board meetings. **(MA 4.4)**

2.35 The Welsh Government's Procurement Policy Note (WPPN) 03/21: Project Bank Accounts Policy requires the establishment of a project bank account for each capital project over £2m; unless there are compelling reasons not to do so. The

UHB's Standing Financial Instructions (SFI's) require that the Director of Finance should apply to WG for any exemption from the use of project bank accounts. Whilst management advised that a project bank account was not being considered for this project, corresponding Welsh Government approval had not been sought. Noting the respective contract values, separate Welsh Government approvals would be required for the enabling and main works contracts. **(MA5.1)**

2.36 A request to award the enabling contract was made to the PFIG Committee on the 30th of April 2024. A review of subsequent UHB Board, UHB Board Sub-Committee and Capital Investment Group Minutes held since November 2023 did not detail any updates being provided on the procurement or contractual issues being experienced in respect of either the main build or the enabling works contracts. **(MA6.1)**

2.37 Given the observations above, **limited assurance** has been determined.

**Contractual Appointments** – *To gain assurance that the Supply Chain Partner and any advisers were appropriately appointed with standardised forms of contracts. A review of the fee management arrangements to date and monitoring/reporting of performance*

*Main construction contract - new build and renovation*

2.38 At the time of the audit fieldwork, the contract for the main works package had been prepared but not signed by either party due to a number of issues. The delay in signing the contract had resulted in a corresponding delay in the ordering of the materials by the Contractor which could ultimately result in an increase to the project outturn costs.

2.39 The April 2024 Performance, Finance & Integrated Governance Committee were advised that the main works had commenced on site in March 2024, with £435k having been recorded against the purchase order to date i.e. in advance of contractual terms having been agreed. It could therefore be determined that this work is currently progressing at risk. **(MA 7.4)** Management recognised the issue and noted that there was a need to co-ordinate approval of the CARR and resulting Purchase Order - whilst the formal completion of the contract is awaited. It was also suggested that both the CARR and Purchase will refer to the form of contract to be applied.

*Enabling Works*

2.40 Noting that the approval to appoint the preferred contractor was only given on the 30th of April 2024, at the time of the audit, corresponding contractual documentation had not been completed.

*Project Manager*

2.41 The Project Manager was appointed from an NHS England Shared Business Services (SBS) framework, which was a direct award from a call off agreement.

2.42 A signed service level agreement (SLA) was provided but only covered a 16-week period 5<sup>th</sup> June 2023 to 29<sup>th</sup> September 2023 for provision of Project Management

services. No further documentation beyond this initial appointment was identified, accordingly the current project management adviser's activities were not covered by a contract. The UHB advised they had taken advice from NWSSP Procurement on this and were confident this could be progressed via a change to the original award, to be actioned at a future date. **(MA7.1)**

#### *UHB Cost Adviser*

2.43 The UHB utilised its own consultant framework to appoint the Cost Advisers and Design Team for the project. These local frameworks sit beneath the threshold of the NHS Building for Wales Framework (£12m) and regional frameworks (£4-£12m).

2.44 However the works cost for this project was significantly above £4m, and approval to this approach was not evidenced – particularly noting that the agreed rates would not recognise the economies of scale of the larger appointment. **(MA7.2)** Furthermore, recognising the value of the appointment, a corresponding project specific call-off contract was not observed. **(MA 7.3)**

2.45 Recognising the issues raised in respect of the procurement and appointment of advisers and the main contractor, **limited** assurance had been determined.

**Design** - *A review of the arrangements to control the development of the design process and to assess the adequacy of the cost planning to date. To include design brief, affordability management of derogations, impact of value engineering / affordability, analysis compliance with design warranties and sign off/approvals.*

2.46 Regular updates were provided on the progress of the design development, including PowerPoint presentations to the Programme Board. The monthly Project Highlight Report detailed design progress, with information replicated within Project Progress Report (PPR) returns made to Welsh Government.

2.47 Site visits and regular design team meetings were reported to have been scheduled during January 2024 with a view to clarifying any queries relating to the design and scope of the early priority works.

2.48 Design user group meetings were held virtually, whilst noting that design was formally discussed the meetings as held did not formally capture that user acceptance had been provided. **(MA8.1)**

2.49 It is important to note that work on site commenced in March 2024.

2.50 Noting that user-group meetings have been held virtually to discuss and agree design **reasonable assurance has been determined** in respect of this objective areas.

**Planning** – *assurance that appropriate arrangements had been made to obtain planning approvals and to clear any associated conditions.*

2.51 Conwy County Council is the local authority with jurisdiction for planning considerations in respect of Llandudno Hospital. It granted a Certificate of Planning

Permission dated 21<sup>st</sup> September 2023. This required that development be started by 28<sup>th</sup> September 2028 and included several planning conditions.

- 2.52 Two further Certificates of Planning Permission were issued on the 29th of September 2023 and 19<sup>th</sup> January 2024 respectively relating to the demolition and alteration works and some latter design changes.
- 2.53 Each of these planning applications are reliant upon set conditions being met.
- 2.54 The UHB's appointed Architect/Design Team maintain a 'condition tracker' however the status of these conditions were not regularly reported to an appropriate forum for scrutiny or to provide assurance. Management have subsequently agreed to request an update from the Architect. **(MA9.1)**.
- 2.55 Noting the above, **reasonable assurance** has been determined in respect of the planning arrangements applied at the project to date.

## Appendix A: Management Action Plan

| Matter Arising 1: Project delays (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Impact                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The fundamental aim of this project was to improve the elective orthopaedic surgical service for North Wales for the benefit of the population, individual patients, and the staff. As of January 2024, the Orthopaedic stage 4 waiting list within BCUHB comprised of 7,643 patients, of which almost 50% had waited more than a year for treatment.</p> <p>One of the main objectives being to develop and commission the new surgical theatres at Llandudno Hospital in an expedited manner in order to quickly improve waiting times and meet the needs of patients. The Programme Initiation Document (PID) detailed that in respect of the Welsh Government “<i>There is ministerial expectation that the project is delivered in year 2024</i>”.</p> <p>The following factors have delayed the project to date:</p> <ul style="list-style-type: none"> <li>• a delay in the formal sign off of main works contract</li> <li>• significant delays were experienced in concluding the enabling works tender, noting that the return was higher than anticipated. At the close of fieldwork, the Performance, Finance &amp; Integrated Governance Committee had approved the appointment of the preferred contractor (30<sup>th</sup> April 2024).</li> </ul> <p>Accordingly, the original anticipated operational date had been revised forward from November 2024 to a current estimated date of the site now planned to be handed over and operational by 25th February 2025.</p> <p>The April 2024 Performance, Finance &amp; Integrated Governance Committee noted that main works had commenced on site in March 2024, with £435k recorded against the purchase order to date i.e. in advance of contractual terms having been agreed. It could therefore be determined that this work is currently progressing at risk</p> | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Project not delivered in the anticipated timescale with a knock-on effect for patients who are currently on waiting lists for orthopaedic surgery.</li> <li>• Failure to meet Welsh Government expectations as regards the expedited delivery of this scheme.</li> </ul> |

| Recommendations          |                                                                                                                          | Priority    |                             |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------|
| 1.1                      | The UHB should as a matter of urgency seek to resolve the contractual issues that have delayed the start of the project. | High        |                             |
| Agreed Management Action |                                                                                                                          | Target Date | Responsible Officer         |
| 1.1                      | <b>Actioned</b> - The contractual issues on the main works contract have now been resolved and contract signed.          | Complete    | Head of Capital Development |

| Matter Arising 2: Minutes of Programme and Project Board Meetings (Design)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Impact                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <p>A Programme Board was established with oversight of all projects that are part of the wider orthopaedic programme. It was noted that the Programme Board met on a fortnightly basis during the period of review.</p> <p>The Programme Board's agenda detailed a standing agenda item on workstream 1a (Llandudno Orthopaedics), however it was not possible to verify the depth of discourse in relation to this due to the minutes not being recorded - the only record of the meeting being an action log. Of particular concern was that the agenda detailed verbal updates on contract and procurement issues, and with the delays experienced and contractual issues that are noted elsewhere in this report, formal recording would have been anticipated.</p> <p>The project specific Project Board was then established and met for the first time in February 2024, despite requests, copies of agendas and recorded minutes of these meetings have not been made available for review.</p> <p>Formal terms of reference for the Project Board have not been produced, however, it was noted that the PEP detailed the following: <i>All meetings of the Project Board would be minuted. Agendas and papers for Project Board meetings would be issued no later than 5 working days prior to each Project Board meeting.</i></p> | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Lack of clear evidence of robust governance.</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Priority                                                                                                                 |
| <p>2.1 The UHB should minute meetings of the Programme Board as a formal record of the discussion, challenge and decision-making processes.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p><b>Medium</b></p>                                                                                                     |
| <p>2.2 Verbal updates to the Programme Board should be by exception only in lieu of full reporting provided</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p><b>Medium</b></p>                                                                                                     |



| 2.3                      | Formal Terms of Reference should be developed for the Project Board, with standing agendas and formal minutes taken of each meeting (in accordance with the requirements of the PEP).                                                                                                | <b>Medium</b>    |                     |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------|
| Agreed Management Action |                                                                                                                                                                                                                                                                                      | Target Date      | Responsible Officer |
| 2.1                      | <b>Actioned</b> – The UHB have introduced formal minute taking in respect of the Programme Board and Project Board meetings from Apr-24 (evidence provided but outside of review timeline).                                                                                          | Completed Apr-24 | Project Director    |
| 2.2                      | <b>Actioned</b> - Verbal updates will be by exception only going forward, however written highlight reports now provided at all meetings re: Capital Update and Overall Programme Update (evidence provided but outside of review timeline).                                         | Completed May-24 | Project Director    |
| 2.3                      | <b>Actioned</b> – The UHB have introduced formal minute taking in respect of the monthly Programme Board meetings from May-24 onwards (evidence provided but outside of review timeline). Minutes are agreed and reviewed in each project board, and stored in a central repository. | Completed May-24 | Project Director    |

| Matter Arising 3: Project Execution Plan (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        | Impact                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The Project Execution Plan is the governing document that establishes the means to execute, monitor, and control individual UHB projects. The plan serves as the main reference document to ensure that everyone is aware and knowledgeable of project objectives and how they will be accomplished. The plan is a live document and should be updated to describe current and future processes and procedures as the project moves through key junctures.</p> <p>The PEP reviewed was v.04 dated 2<sup>nd</sup> October 2023 and had been produced by the UHB's advisors.</p> <p>The PEP appeared to have been developed for a previous project as it contained management comments pertaining to a different live project. As such the governance arrangements did not reflect those detailed within the programme level PID e.g. omitting details of the Programme Board. The section in the PEP detailed as Project- 'aims and objectives' was left blank with the comments 'to be provided by BCUHB'.</p> <p>The remaining content of the PEP included the various sections expected.</p> |                                                                                                                                        | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>The PEP may not reflect agreed revisions, and therefore does not fulfil its purpose as a source of reference for the governance of the project.</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        |                                                                                                                                                                                                                             |
| 3.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The PEP should be reviewed and updated to reflect this project.                                                                        | <b>Medium</b>                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | Target Date                                                                                                                                                                                                                 |
| 3.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Agreed</b> - the PEP is to be updated to reflect current project status and the governance refresh agreed following Gateway review. | Aug-24                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | Head of Capital Development                                                                                                                                                                                                 |

| Matter Arising 4: Works Procurement (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Impact                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The UHB's Procedure Manual for Managing Capital Projects notes that:</p> <p><i>Tenders over £1m must be submitted by the Project Board to the Director of Finance and the Health Board for approval.</i></p> <p>The Procedure Manual further incorporates several templates to be utilised, including a contract recommendation form.</p> <p>A Contract Award Recommendation Report (CARR) was produced for both the enabling and main works. Whilst the Enabling Works CARR was signed by the Director of Finance, the CARR for the main works was not. Similarly, the Enabling works CARR was submitted to the Performance, Finance &amp; Integrated Governance Committee for approval, there is no evidence of the main works CARR having been approved by an appropriate forum.</p> <p>In reviewing the CARR for each project, the following is noted:</p> <ul style="list-style-type: none"> <li>• The commercial evaluation of the enabling works is based on divergence from lowest bid. Noting there is only one bid, the tenderer scored fully (65 out of 65). The report does not detail how value for money has been demonstrated (e.g. benchmarked against other project costs or against a pre-tender estimate of the costs) – particularly noting that the Cost Adviser evaluation report does not specify whether value for money has been achieved and/or make a recommendation to the UHB.</li> <li>• Key omissions to the tenders have not been highlighted (e.g. radiation protection and raising of theatre extension floor).</li> <li>• Risks highlighted by the cost adviser have not been noted around higher than anticipated costs.</li> <li>• The number of unaddressed comments and unsubstantiated costs have not been detailed.</li> </ul> <p>To avoid disruption to the programme, an element of priority works of £1.3m has been transferred from the enabling works to the main scheme – to be instructed as a change. Corresponding approval to shift the funding and change the scope of both projects was not evidenced at the audit.</p> | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Approval process not followed, in breach of UHBs SFIs.</li> <li>• Value for Money is not demonstrated.</li> </ul> |

| From the various reports reviewed, it is concluded that the pre-tender estimates could not be used as a reliable benchmark as they were not updated for revised design changes. |                                                                                                                                                                                                               |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Recommendations                                                                                                                                                                 |                                                                                                                                                                                                               | Priority                    |
| 4.1                                                                                                                                                                             | The cost adviser should be required to confirm retrospectively whether value for money has been achieved and should recommend whether to appoint the preferred bidder (or not).                               | High                        |
| 4.2                                                                                                                                                                             | The UHB Contract Award Recommendation Report should detail in full any limitations and/or risks that may be pertinent to the decision-making process – confirming that the value for money has been achieved. | High                        |
| 4.3                                                                                                                                                                             | Retrospective approval should be obtained to appoint the preferred contractor for the main works project.                                                                                                     | High                        |
| 4.4                                                                                                                                                                             | The UHB should ensure that changes of works packages post tender are appropriately reported and approved.                                                                                                     | High                        |
| 4.5                                                                                                                                                                             | For future projects the use of pre-tender estimates as a reliable predictor of cost should be taken with an air of caution, with further methods of design cost appraisal considered.                         | Medium                      |
| 4.6                                                                                                                                                                             | Welsh Government approval will be secured to release the required amount of Welsh Government held contingency – in the interim, this should be recorded at the project risk register.                         | Medium                      |
| Agreed Management Action                                                                                                                                                        |                                                                                                                                                                                                               | Target Date                 |
| 4.1                                                                                                                                                                             | <b>Actioned</b> - The HB received two submissions for the main contract works which allowed commercial comparison between                                                                                     | Complete                    |
|                                                                                                                                                                                 |                                                                                                                                                                                                               | Head of Capital Development |

|     |                                                                                                                                                                                                                                                                                                                                                                                                                  |          |                             |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------|
|     | both contractors. Contractors were vetted both on technical and commercial criteria. The appointed contractor scored highest on both commercial and technical. This allowed the cost advisors confirm value for money. KPI meetings arranged for October 2024.                                                                                                                                                   |          |                             |
| 4.2 | <b>Actioned</b> - On submission and award of the tender the risk register was reviewed and adjusted in line with tender submission. The relevant risks were maintained, closed risks were omitted / reduced. Value for money covered in 4.1. To be covered during October 2024 KPI review.                                                                                                                       | Complete | Head of Capital Development |
| 4.3 | <b>Agreed</b> – Discussions to take place with DoF/Deputy DoF to discuss most appropriate approval route.                                                                                                                                                                                                                                                                                                        | Aug-24   | Head of Capital Development |
| 4.4 | <b>Agreed</b> - Changes to works packages are approved in line with the health board's capital procedures manual and the change control process noted within the PEP.<br><br>Going forward full cost report will be issued to the project board for information / approval. Cost report No 6 included in September Project Board Meeting. Any significant variations are highlighted within PM highlight report. | Sept-24  | Senior Project Manager      |
| 4.5 | <b>Actioned</b> – Agree, sufficient time should be allowed within business case preparation to provide fully tendered at                                                                                                                                                                                                                                                                                         | Complete | Head of Capital Development |

|     |                                                                                                                                                                                                                                                                                                                                                                                        |          |                             |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------|
|     | submission stage. Due to the time constraints this was not feasible within this scheme.                                                                                                                                                                                                                                                                                                |          |                             |
| 4.6 | <b>Actioned</b> - The amount required from the WG held contingency was reported at Project Board, PFIG and WG meetings following the enabling works tender receipt. Any changes to this requirement will be reported through project board risks recorded on the risk register and highlighted through the cost reports. PPR report are provided direct to WG provided regular updates | Complete | Head of Capital Development |

| Matter Arising 5: Project Bank Account (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                |                     | Impact                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------|
| <p>Welsh Procurement Policy Note (WPPN 03/21) requires:</p> <p><i>All Welsh Government construction and infrastructure contracts and any other 'appropriate contracts' valued at £2m or more (see section 3.2) which are delivered directly on behalf of Welsh Government Departments that require a PBA be applied unless there are compelling reasons not to do so.</i></p> <p>The UHB's SFI's further clarify that:</p> <p><i>15.4.8 The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.</i></p> <p>Management advised that the Project Bank Account was not being considered for this project, however formal approval from Welsh Government had not been sought/ secured at the time of the review (note that exemption would be required for both the enabling and main works would be required).</p> |                                                                                                                                                                                |                     | <p>Potential risk of:</p> <p>In breach of Welsh Government requirements and not in compliance with UHB SFIs.</p> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                |                     | Priority                                                                                                         |
| 5.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Formal Welsh Government approval is required to avoid using the Project Bank Account at both the enabling and main works contracts.                                            |                     | High                                                                                                             |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                | Target Date         | Responsible Officer                                                                                              |
| 5.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Agreed</b> - The contractor is willing to set up a project bank account, we are currently exploring the process and timescale. Contractor have been instructed to progress. | Estimated late 2024 | Head of Capital Development                                                                                      |



| Matter Arising 6: Project progress reporting (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                | Impact                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The procurement process to appoint a Supply Chain Partner was completed by the end of November 2023.</p> <p>UHB's SFI require:</p> <p><i>15.34.4 notes recording that 'regular updates must be provided to the Board, and relevant Board Committees, during the financial year'.</i></p> <p>The Project Highlight report dated 15<sup>th</sup> December 2023 records that:</p> <p><i>The original programme targeted a start on site date at the end of 2023. Due to delays in receiving approval to proceed and subsequently co-ordination of design information that is now unachievable. The revised programme will be targeting a January start date and completion in Winter 2024.</i></p> <p>A review of Board, Board Committees and Capital Investment Group Minutes that were held after the closure of the tender exercise in November 2023 did not detail any updates being provided on the procurement or contractual issues being experienced in respect of either the main build package or the enabling works.</p> |                                                                                                                                                                                                                                                                | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>The Board and its Sub-committees are not kept adequately appraised of key issues in respect of the delivery of this project.</li> <li>SFIs pertaining to Capital Schemes are not complied with.</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                | Priority                                                                                                                                                                                                                                                                    |
| 6.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | The UHB should ensure that regular updates on the Project are provided to the various groups and committees.                                                                                                                                                   | <b>High</b>                                                                                                                                                                                                                                                                 |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                | Target Date                                                                                                                                                                                                                                                                 |
| 6.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Actioned</b> - Regular updates/presentations have been provided to the Executive Team following requests from the CEO. As a key deliverable within our Special Measures Framework, monthly updates are provided via the governance route or the Annual Plan | Complete                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                | Responsible Officer                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                | Programme Director                                                                                                                                                                                                                                                          |

| Matter Arising 7: Appointment of UHB Advisers (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                           | Impact                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The UHB appointed external professional advisers as follows:</p> <ul style="list-style-type: none"> <li>The Project Manager was appointed from an NHS England Shared Business Services (SBS) framework based on a direct award and call-off agreement. The call-off agreement provided was appropriately signed by both parties but only covered a 16- week period 5th June 2023 to 29th September 2023. The UHB have since advised that NWSSP Procurement have been consulted in respect of this issue, and advice as received to date indicates this is not considered to present a significant risk and will be addressed accordingly through an extended signed agreement.</li> <li>The Cost Advisers, Design Consultants and CDM (Construction Design and Management) Advisers were appointed from the UHB's own local framework. The framework was initially let to target projects below the NHS Building for Wales Framework to a maximum works value of £7m. Given the value of the works for this element (£16.177m), the UHB may not have benefitted from economies of scale associated with larger value projects. Approval to progress with this strategy was not observed. Additionally, call-off contracts were not completed for these appointments.</li> <li>Furthermore, recognising the value of the appointment a corresponding project specific call-off contract was not observed.</li> </ul> |                                                                                                                                                           | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>UHB and supplier not clear on expectations and obligations.</li> <li>The interests of the UHB are not adequately protected under contract.</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                           |                                                                                                                                                                                                                        |
| 7.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | The UHB should ensure that contracts are in place for all adviser appointments to protect the interests of the UHB.                                       | High                                                                                                                                                                                                                   |
| 7.2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Retrospective approval should be sought for the procurement approach adopted for the appointment of the Cost Adviser, Design Consultants and CDM Adviser. | Medium                                                                                                                                                                                                                 |
| 7.3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A project specific call-off contract in respect of these appointments should be completed.                                                                | High                                                                                                                                                                                                                   |

|                                 |                                                                                                                                                                                                                                |               |                             |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------|
| 7.4                             | For future projects the UHB should ensure that contracts are signed before commencement of works.                                                                                                                              | <b>Medium</b> |                             |
| <b>Agreed Management Action</b> |                                                                                                                                                                                                                                |               |                             |
| 7.1                             | <b>Actioned</b> – Detail as per 7.2                                                                                                                                                                                            | Complete      | Head of Capital Development |
| 7.2                             | <b>Actioned</b> – However, the design team, cost advisors and CDM advisors are all from the health board local design team frameworks. The external PM was appointed on the SBS framework as supported by procurement.         | Complete      | Head of Capital Development |
| 7.2                             | <b>Actioned</b> - The initial works packages were under £7m, however this procurement plan changed during the design stage that led to contract values over £7m. For future health board framework inception forms to be used. | Complete      | Head of Capital Development |
| 7.4                             | <b>Actioned</b> – Cost Advisor are instructed to prepare contract prior to pre-start meeting.                                                                                                                                  | Complete      | Head of Capital Development |

| Matter Arising 8: Design sign off (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                               |        | Impact                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Through the duration of the project to date, the UHB has held User meetings, with separate groups to discuss discrete areas of design. In keeping with many contemporary meetings these are now held virtually. Whilst noting there are records demonstrating that the meetings have been held, and the make-up of the attendees, formal sign off if designs is not captured. Formal user sign is important in the event of any future disputes arising in respect of design specifications. |                                                                                                                                                                                                                               |        | Potential risk of: <ul style="list-style-type: none"> <li>Design does not meet user expectations due to lack of formal engagement.</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                               |        |                                                                                                                                               |
| 8.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.                                                                            |        | Low                                                                                                                                           |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |        |                                                                                                                                               |
| 8.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Agreed</b> - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward. | Aug-24 | Senior Project Manager                                                                                                                        |

| Matter Arising 9: Planning Conditions (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                    | Impact                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Conwy County Council is the local authority with jurisdiction for planning considerations in respect of Llandudno Hospital. It granted a Certificate of Planning Permission dated 21<sup>st</sup> September 2023. This required that development be started by 28<sup>th</sup> September 2028 and included several conditions that were to be met to ensure compliance with the terms of the planning permission.</p> <p>Those conditions that preclude any work on site have been addressed with further conditions currently being the subject of measures to ensure they are met.</p> <p>Two further Certificates of Planning Permission were issued on the 29<sup>th</sup> September 2023 and 19<sup>th</sup> January 2024 respectively relating to demolition and alteration works and some latter design changes. Again, these planning applications are reliant upon conditions as detailed being met.</p> <p>The UHB's appointed Architect/Design Team maintain a 'condition tracker' however the status of these conditions were not regularly reported to an appropriate forum.</p> |                                                                                                                    | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Lack of assurance that planning conditions have been met prior to commencement of key aspects of the project, which have been highlighted within the Planning consent.</li> <li></li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                    |                                                                                                                                                                                                                                                              |
| 9.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | The condition tracker maintained by the UHBs design team should be shared and discussed at Project Board Meetings. | Low                                                                                                                                                                                                                                                          |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                                                                              |
| 9.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Agreed</b> - condition tracker to be requested from Architect and submitted as appendices to highlight report.  | <p>Sept-24</p> <p>Senior Project Manager</p>                                                                                                                                                                                                                 |

## Appendix B: Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

|                                                                                    |                                 |                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|    | <b>Substantial assurance</b>    | Few matters require attention and are compliance or advisory in nature.<br><b>Low impact</b> on residual risk exposure.                                                                                                                                    |
|    | <b>Reasonable assurance</b>     | Some matters require management attention in control design or compliance.<br><b>Low to moderate impact</b> on residual risk exposure until resolved.                                                                                                      |
|    | <b>Limited assurance</b>        | More significant matters require management attention.<br><b>Moderate impact</b> on residual risk exposure until resolved.                                                                                                                                 |
|   | <b>Unsatisfactory assurance</b> | Action is required to address the whole control framework in this area.<br><b>High impact</b> on residual risk exposure until resolved.                                                                                                                    |
|  | <b>Assurance not applicable</b> | Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.<br>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    |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| <b>High</b>    | Poor system design OR widespread non-compliance.<br>Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. | Immediate*           |
| <b>Medium</b>  | Minor weakness in system design OR limited non-compliance.<br>Some risk to achievement of a system objective.                                                           | Within one month*    |
| <b>Low</b>     | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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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# Corporate Legislative Compliance - Fire Safety

## Internal Audit Report

October 2024

Betsi Cadwaladr University Health Board



Partneriaeth  
Cydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
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Betsi Cadwaladr  
University Health Board



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|                               |                                                                                                                        |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------|
| Review reference:             | BCUHB-2425-16                                                                                                          |
| Report status:                | Final                                                                                                                  |
| Fieldwork commencement:       | 17 June 2024                                                                                                           |
| Fieldwork completion:         | 5 August 2024                                                                                                          |
| Debrief meeting:              | 6 August 2024                                                                                                          |
| Draft report issued:          | 9 August 2024                                                                                                          |
| Management response received: | 9 October 2024                                                                                                         |
| Final report issued:          | 15 October 2024                                                                                                        |
| Auditors:                     | Dave Harries, Head of Internal Audit<br>Nicola Jones, Deputy Head of Internal Audit<br>Ossama Lotfy, Principal Auditor |
| Executive sign-off:           | Russell Caldicott, Interim Executive Director of Finance                                                               |
| Distribution:                 | Arwel Hughes, Head of Operational Estates<br>Gareth Griffiths, Senior Estates Officer (SEO) – Legislation Assurance    |
| 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 Chartered Institute of Public Finance & Accountancy in April 2023.

**Acknowledgement:** NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during 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.

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

## Executive Summary

### Purpose

To assess compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', which provides practical guidance in the application of statutory regulation in healthcare premises.

### Overview

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

- Fire safety reporting and committee structure needs review, some group meetings are not taking place at the required frequency and there is a lack of assurance to the Health Board.
- The Policy for the Management of Fire Safety (ES04) is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements. This is recognised by management.
- The audit identified non-compliance with Mandatory fire training requirements as stated in the Fire Safety policy. This is an operational management responsibility to ensure compliance.
- The report for the last annual management fire audit was submitted outside the recognised timeframe. We have not been able to verify evidence of submission.
- A number of issues were identified through site testing that are non-compliant with the Management of Fire Safety Policy, such as Fire Fighting Equipment (FFE) not being regularly serviced, out of date risk assessments and a lack of regular fire drills and evacuations.

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

## Report Opinion

Limited



More significant matters require management attention.

**Moderate impact** on residual risk exposure until resolved.

Trend



## Assurance summary<sup>1</sup>

| Objectives                                                                                                                                                          | Assurance  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 1 There are appropriate governance arrangements in place for fire safety.                                                                                           | Limited    |
| 2 There are appropriate policies and procedures in place that outline requirements of staff and monitoring arrangements, and these have been communicated to staff. | Reasonable |
| 3 There is effective central monitoring and reporting to ensure compliance with the Health Board's Policy and legislation.                                          | Limited    |
| 4 There are effective local arrangements in place to manage fire risks.                                                                                             | Limited    |

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

| Key Matters Arising |                                                                                                                                                                                                                                                                  | Objective | Control Design or Operation | Recommendation Priority |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------|-------------------------|
| 1                   | Fire safety reporting and committee structure requires review as meetings are not taking place at the required frequency, and there is no evidence of assurance on fire safety arrangements to a committee / strategic group.                                    | 1         | Design                      | High                    |
| 2                   | The Policy for the Management of Fire Safety (ES04) is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements.                                                                        | 2         | Design                      | Medium                  |
| 3                   | Several fire risk assessments have passed their due date (red) and in some cases assessments have not been undertaken since 2020 and 2021. This was confirmed during site visits where risk assessments in two sites were not up to date and required reviewing. | 3         | Operation                   | Medium                  |
| 4                   | The audit identified non-compliance with training requirements stated in the Fire Safety policy.                                                                                                                                                                 | 3         | Operation                   | High                    |
| 5                   | The report for the last annual management fire audit was submitted outside the recognised timeframe. We have not been able to verify evidence for submission.                                                                                                    | 3         | Operation                   | High                    |
| 6                   | Non-compliance with elements of the Fire Policy were identified through site visits. These are detailed in Appendix C of this report.                                                                                                                            | 4         | Operation                   | High                    |

## 1. Introduction

1.1 On 1 November 2006, Welsh Assembly Government issued Welsh Health Circular (WHC) (2006) 74 Fire Safety Policy for the NHS Estates in Wales, that requires an effective fire policy that sets a clear direction for the organisation to follow.

1.2 The Health Board's Policy for the Management of Fire Safety (ES04) states:

*The Health Board acknowledges the Welsh Government's fire safety policy statement published under cover of WHC (2006) 74 and aims to meet the primary objectives required by the Welsh Government to:*

- *Minimise the incidence of fire throughout the Health Board estate: and property.*
- *Minimise the impact from fire on life safety, delivery of service, the environment and property.*

*This policy applies to all premises owned or occupied by the Health Board.*

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

- Inadequate arrangements are in place to manage fire precaution requirements at Health Board sites.
- Inadequate monitoring and reporting arrangements do not provide management and the Board with appropriate assurances.
- Non-compliance with legislation which may lead to legal action and adverse publicity.
- Inadequate response procedures and responsibilities, exposing staff and patients to unacceptable levels of risk.

## 2. Detailed Audit Findings

This report is based upon the information provided by the Senior Estates Officer (SEO) Legislation Assurance and Fire officers (East, Central & West) as well as supplementary information obtained/responses made during discussions. We would like to express our gratitude to colleagues for their input during the undertaking of the review.

We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

Our sample of documentation was based on visits to the three main hospital sites and three community sites (one area / ward at each site). A breakdown of findings at each site can be found in Appendix C.

**Objective 1: There are appropriate governance arrangements in place for fire safety.**

2.1 Governance of fire safety is provided through the Fire Safety Management Group (FSMG) which is a sub group of the Strategic Occupational Health and Safety Group

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(SOHSG), which in turn reports to the Quality Safety and Experience Committee (QSE).

Corporate Management Reporting Structure for fire safety lies with:

- Health Board Responsible Person – Chief Executive
- Board Level Director – Director of Finance
- Fire Safety Manager – Director of Environment (Vacant)
- Assistant Fire Manager – Head of Operational Estates (Fire Safety Manager during transitional period)
- Deputy Fire Safety Manager – Operational Estates Manager East, West and Central

2.2 Fire safety reporting groups are:

- Quality Safety and Experience Committee (to April 2024), People and Culture Committee (April 2024 onwards)
- Strategic Occupational Health and Safety Group
- Fire Safety Management Group (FSMG)
- Operational Estates area Fire Safety Group
- IHC East, West and Central. (Acute and Community)

2.3 As noted in objective 2 below, the Health Board policy for fire safety is overdue for review and as such, it does not reflect current management structure and existing governance arrangements. However, we do recognise that this is under review.

2.4 We reviewed papers and minutes of the above-mentioned groups and committees and confirmed they meet at regular intervals per agreed Terms of Reference, apart from the following:

- Quality Safety and Experience Committee - the Senior Estates Officer (SEO) / Legislation Assurance advised that the reporting method to this Committee is via the Strategic Occupational Health and Safety Group (SOHSG) Chairs report. We reviewed QSE papers for February, March and April 2024, which did not include any issues of significance for fire safety.
- People and Culture Committee – we reviewed papers for June and August 2024, which did not include any reporting from the Strategic Occupational Health and Safety Group (SOHSG). The approved Terms of Reference for the Committee does not state that chairs reports will be received from the SOHSG, however the cycle of business includes a requirement for a Chairs Assurance Report from the SOHSG in June and December 2024.
- Strategic Occupational Health and Safety Group (SOHSG) - this should meet every two months – We noted that meetings have taken place on 18 December 2023 and 2 April 2024 with the agenda provided for the date of the next meeting being 25 June 2024.

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Conclusion:

- 2.5 There are governance arrangements in place for the management of fire safety within the Health Board. This includes several groups with a reporting route to the Quality Safety and Experience Committee (People and Culture Committee from April 2024). There is no evidence of reporting to the QSE for scrutiny or assurance, we are advised reporting is on an exception basis however this does not provide the Health Board with appropriate assurance on fire safety matters. We are advised reporting is now through the People and Culture Committee, however no Chairs Assurance Report has been received at the Committee to date.

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

**Objective 2: There are appropriate policies and procedures in place that outline requirements of staff and monitoring arrangements, and these have been communicated to staff.**

- 2.6 The Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy point 4 Mandatory Requirements for the NHS in Wales state:

*All NHS organisations must:*

*Have a clearly defined fire safety policy covering all buildings they occupy.*

- 2.7 The Policy for the Management of Fire Safety (ES04) had been developed in accordance with above requirements and endorsed by the Quality Safety and Experience Committee. This policy applies to all premises owned or occupied by the Health Board and is located on the Health Boards Fire Management intranet page. Through our testing, we confirmed that the policy has been appropriately communicated to all Fire Wardens.

- 2.8 Section 1.1 Policy Aims states:

*"The Health Board acknowledges the Welsh Government's fire safety policy statement published under cover of WHC (2006) 74 and aims to meet the primary objectives required by the Welsh Government to:*

- Minimise the incidence of fire throughout the Health Board estate: and property.*
- Minimise the impact from fire on life safety, delivery of service, the environment and property."*

During site visits we confirmed that current policy meets the aims, however this is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements.

- 2.9 Estates advised the policy is under review and on hold in line with all Operational Estates policies until appointment to the current vacant post of Director of the Environment. Once agreed it will be presented to the Strategic Occupational Health and Safety Group (SOHSG) for approval and ratified through the Quality Safety and Experience Committee. We have not been given a specific date as to when this would be completed and highlight this as a significant risk area where the Health Board must have a current policy in place for Statutory compliance.



### Conclusion:

2.10 The Policy for the Management of Fire Safety (ES04) covers statutory areas required to create and maintain an environment that will ensure that its premises, staff and contractors comply with statutory requirements. However, the policy is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements. Management are aware of this and are awaiting the appointment of a Director of Environment to progress. However, we believe this Policy review must be progressed at pace recognising the significance of Statutory compliance in this area.

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

### **Objective 3: There is effective central monitoring and reporting to ensure compliance with the Health Board's Policy and legislation.**

#### **Fire Risk Assessments (FRA's)**

2.11 The number of FRA's completed is reported at each Fire Safety Management Group meeting using data collected by the NWSSP-SES system.

2.12 Chapter 5 Effective Fire Safety Management / Point 5.2 of the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', states

*In all but the smallest of healthcare organisations it will be necessary to develop a fire safety management system to ensure that an appropriate fire-safe environment is maintained. A fire safety management system should ensure that:*

- a suitable and sufficient assessment of fire risks is undertaken throughout the relevant areas of all premises owned, occupied and/or managed by the organisation;*
- fire risk assessments are maintained up-to-date and are reviewed as appropriate;*

2.13 Estates advised that FRA's review period is based on the recommendations contained in the HTM 05-03 Part K. There is no specific documented review period for fire risk assessments, however the following paragraph is contained within the guidance document, which is the recognised guide for complex healthcare premises.

*"Assessments should be kept under constant review, and in any case reviewed whenever circumstances change that affect the validity of the current assessment. While there is no maximum period between assessments, industry guidance recommends that the review period should not exceed 12 months. In healthcare premises, the review period should be based on the risk, including the dependency of the patient. Whereas for high risk (including very high dependency) the review period may be considerably less than 12 months, where the risk is low, it may exceed 12 months."*

2.14 We have received a Fire Risk Assessments (FRA's) Report which shows number and due dates of FRA's completed at all Health Board premises.

- 2.15 Several risk assessments have passed their due date (red) and in some cases going back to 2020 and 2021. This was confirmed during site visits where risk assessments in two sites were not up to date and required reviewing.
- 2.16 The below table is a summary of percentage of FRAs overdue for review across the Health Board.

|              | Number of Premises | Number of Areas | Number of assessment areas overdue for review | % Non-compliance |
|--------------|--------------------|-----------------|-----------------------------------------------|------------------|
| East         | 44                 | 215             | 55                                            | 25.58%           |
| Central      | 53                 | 249             | 63                                            | 25.30%           |
| West         | 40                 | 252             | 71                                            | 28.17%           |
| <b>Total</b> | <b>137</b>         | <b>716</b>      | <b>189</b>                                    | <b>26.40%</b>    |

Source - FRA's report provided by Estates as in April 2024.

- 2.17 This was queried with the Senior Estates Officer (SEO) / Legislation Assurance, and they advised that:

*"The Fire Risk Assessment Report is discussed at the Fire Safety Management Group (FSMG), it is to update the group in relation to the current position with the completion of reviews of FRA's across BCUHB.*

*We have been experiencing challenges in completing the reviews within the expected timeframes for a number of years, which was exacerbated by Covid and the loss of a staff member during that time.*

*As we play catch up we are prioritising the reviews by concentrating on the inpatient areas which provide overnight sleeping accommodation in the first instance".*

### Fire Safety Training

- 2.18 Estates advised that training is undertaken in accordance with the training plan contained within table one of the fire safety policy (ES04). To comply with the relevant articles of the Fire Safety Order, attendance records are maintained together with personal records within the Electronic Staff Record (ESR) system.
- 2.19 We received a report showing status of fire wardens training across the Health Board. Fire Warden training is delivered face to face or through Teams and is recorded on individuals ESR, however Estates advised this is not reported centrally.
- 2.20 A sample of five random staff members was selected to test compliance against mandatory training requirements as stated in the Fire Safety policy – none of them show compliance against defined requirements and this was queried with the Senior Estates Officer (SEO) / Legislation Assurance who advised that:

*"Responsibility for ensuring that mandatory training including fire is undertaken within the requisite timeframe rests with the staff member themselves and monitored by their line manager. During the fire risk assessment process the fire safety advisor will ask the responsible person for the area whether the staff under their responsibility have undertaken the requisite fire safety training and request*

*the current percentage compliance and any reason for the shortfall e.g. long-term sickness”.*

- 2.21 The table below shows the status of Electronic Staff Record (ESR) fire safety mandatory training. Across the Health Board the compliance rate as at end of June 2024 was 89.77%.

| Organisation                               | Compliant    | Non-compliant | % Compliance  |
|--------------------------------------------|--------------|---------------|---------------|
| Integrated Health Community East           | 4507         | 627           | 87.78%        |
| Integrated Health Community Central        | 4620         | 519           | 89.90%        |
| Integrated Health Community West           | 3719         | 422           | 89.81%        |
| Integrated Clinical Delivery Primary Care  | 473          | 173           | 95.56%        |
| Integrated Clinical Delivery Regional Care | 1306         | 154           | 88.30%        |
| Midwifery and Women's Services             | 752          | 51            | 93.65%        |
| Corporate Services                         | 1782         | 211           | 89.41%        |
| <b>Total</b>                               | <b>17159</b> | <b>2157</b>   | <b>89.77%</b> |

Source – Fire safety ESR report provided by Estates as at end of June 2024.

### Fire Incidents and Unwanted Fire Signals

- 2.22 All fire incidents and unwanted fire signals are recorded on the NWSSP-SES system. Each incident is investigated and actioned appropriately, but not all fire incidents will generate an action plan.
- 2.23 These incidents are reported through the Fire Safety Management Group, and if necessary escalated via the Strategic Occupational Health and Safety Group. We are advised that local fire advisors will report back through relevant Integrated Health Communities, however we are not sighted on the process for reporting to other areas, such as corporate or other divisions.
- 2.24 Estates advised that the Health Board have not received any Fire Safety Enforcement Notices from the North Wales Fire Authority. However, all letters following audits which contain recommendations are reported through the Fire Safety Management Group (FSMG) and escalated through the Strategic Occupational Health and Safety Group, with reports also going to the relevant IHC. As above, we are unsighted on the arrangements for reports to other areas outside of IHCs, such as corporate areas or other divisions.
- Actions are followed up through the fire safety advisor, the relevant health and safety group of the IHC and Operational Estates.
- 2.25 The Health Board is required to submit an annual audit report to provide assurance on fire safety. The report for the last annual management fire audit was submitted

outside its recognised timeframe, with the 2022/23 audit report being submitted in April 2024. We are advised outcomes were reported through FSMG but have been unable to verify evidence of submission.

#### Conclusion:

- 2.26 The number of outstanding / overdue Fire Risk Assessments across Health Board areas in April 2024 was 189 (26.40%). In some areas the last risk assessments were in 2020 and 2021. This was confirmed during site visits where risk assessments in two sites were not up to date and required reviewing.
- 2.27 A sample of staff reviewed did not have the required Mandatory fire training as stated in the policy. Training data is not captured centrally to provide assurance that this is being undertaken by those who require it.
- 2.28 The report for the last annual management fire audit, which provides assurance on all areas of fire safety within the Health Board, was submitted almost one year outside the recognised timeframe. We have not been able to verify evidence for submission.

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

#### **Objective 4: There are effective local arrangements in place to manage fire risks.**

- 2.29 The Policy for the management of Fire Safety, Point 7 Site Specific Procedures, states:

*A "Site Specific Guidance and Documentation Manual" will be held at each of the Health Board sites. The procedures will identify the action to be taken by members of staff. They should be mutually agreed and be kept in an agreed location within the premises so that it is easily accessible when required. The contents of the Manual should be laid out under headings in the form of an aide memoir (WHEN 09/16), which will be easy to follow and to manage.*

- 2.30 We sampled documentation for three main hospital sites which included Outpatients department, Orthopaedics Ward and Theatres and three community sites which included two Care of the Elderly wards and Outpatients department.
- 2.31 The Corporate Fire Department had developed Fire folders at or near the main entrances of all the hospitals we sampled, this was further embedded by fire specific folders for wards within the acute hospitals. A consistent approach was followed throughout the Health Board towards the fire folders with regards to the information contained in them.

The following areas of good practice were identified:

#### **Operational Fire Strategy / Plan Documents**

- 2.32 Operational Fire Strategy / Plan Documents were available at all sites together with Personal Emergency Evacuation Plans (PEEPs) in relation to the risk profile of ward/area concerned.

Those were contained within the site-specific documents and include access

restrictions and other arrangements to distinguish critical and patient areas.

### **Fire Safety Signage**

- 2.33 Appropriate fire safety signage was visible at all sites.

### **Fire Alarms**

- 2.34 Weekly fire alarm tests are undertaken across all sites and recorded within the Estates GRAMMS management system.

### **Protection of Highly Flammable Substances**

- 2.35 Each department area is required to keep a Control of Substances Hazardous to Health (COSHH) register, all qualifying substances are to be kept within appropriate storage conditions. This is reviewed as part of the fire risk assessment process.
- 2.36 In all sites medical gases are stored externally within appropriate compounds, ward and site-based equipment are stored on appropriate stands and their location is reviewed as part of the fire risk assessment process.

The following issues were identified:

### **Fire Wardens**

- 2.37 The role of Fire Wardens is covered within paragraph 4.12 of the policy:

*"Fire Wardens will be appointed by the Designated Responsible Person in all hospital wards and departments (and clinics where appropriate) to assist the with fire safety management. Fire Wardens shall be made aware as to the extent of the area that they are to cover and the extent of their responsibilities in that location".*

In all sites visited there were lists of fire wardens available, however this was not locally displayed at four of the six sites to enable staff to identify their names and contact details in an emergency.

### **Fire Action Notices**

- 2.38 In two sites it was noted that fire action notices do not state where the nearest fire alarm point is (left blank).

### **Fire Fighting Equipment (FFE)**

- 2.39 FFE is provided within Health Board premises in accordance with the requirements of the Fire Safety Order. The review of the location of the FFE is reviewed as part of the fire risk assessment review process. Fire Fighting Equipment servicing is outsourced to an external company, via a Health Board wide tender process.

Estates advise that due to delays with the tendering process there are some areas which are over-due for servicing. This was evidenced at one of the hospital sites visited, where all equipment was out of date and last inspected January 2023, and some fire extinguishers last inspected in November 2017.

The company awarded the contract are currently undertaking a servicing

programme to test all outstanding firefighting equipment. We are advised that the servicing contract for Ysbyty Gwynedd, Ysbyty Glan Clwyd, Wrexham Maelor have been completed. Central and East community have also been completed and they are working in West at present.

### **Annual Inspection / Test Program**

2.40 Fire safety dry risers, hydrants, emergency lighting and fire alarm systems are subjected to an annual test. We were provided with inspection / test certificates for all sites and the following issues were identified:

- In Chirk Community Hospital there is one hydrant to the rear of the building. We checked with Estates to obtain the latest inspection certificate, and were advised *"There are no up to date test records within Operational Estates. We are awaiting a response from the Fire and Rescue Service to see if this hydrant is on the Water Board info structure and therefore under their responsibility for testing and maintenance or on a branch supply under the control of the Health Board. Once we receive a response will ensure, if necessary, appropriate remedial action is taken"*.

Estates further advised that North Wales Fire and Rescue Service confirmed that the hydrant at the rear of Chirk Hospital is on a branch main under the control of the Health Board. Operational Estates requested to have the hydrant tested and included on a maintenance regime.

- A regime for the testing of fire doors across the Health Board does not exist at the moment. Estates advised this has been recognised and they are looking at options to address this matter including outsourcing to an external provider.
- At one community hospital site we were provided with a Fire Detection & Alarm System Inspection and Servicing Certificate, but this was dated February 2023, also a Smoke Damper Test Certificate was dated October 2022, with no further inspections since.

### **Fire Evacuation Drills**

2.41 For all sites, fire evacuation drills have not been undertaken for a number of years, with some recently being competed in some hospital sites.

The Senior Estates Officer (SEO) – Legislation Assurance advised that on a Health Board wide basis fire drills are undertaken but not with the preferred regularity.

2.42 The full breakdown of what was identified at each site can be found in Appendix C.

### **Conclusion:**

2.43 Several issues were identified through site testing that are non-compliant with the Management of Fire Safety Policy, such as Fire Fighting Equipment (FFE) not being regularly serviced, out of date risk assessments and a lack of regular fire drills and evacuations. These are detailed in Appendix C of this report.

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

## Appendix A: Management Action Plan

| Matter Arising 1: Governance (Design)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              | Impact                                                                                                                                                                                              |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| <p>We have received copy minutes of fire safety reporting groups and committees, and the following was noted:</p> <ul style="list-style-type: none"> <li>- Quality Safety and Experience Committee – Estates advised that the reporting method to this committee is via the Strategic Occupational Health and Safety Group (SOHSG) Chair report. Estates have not received any copies of minutes and they believe that following a review of the Board's committees, the SOHSG reports to the People and Culture Committee. A review of QSE papers confirm that there is no reporting on fire safety.</li> <li>- Strategic Occupational Health and Safety Group (SOHSG) - This should meet every two months however we noted there was a four-month gap between the December 2023 and April 2024 meeting but recognise that it has met in April and June 2024 since.</li> </ul> |                                                                                                                                                                                              | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Inadequate monitoring and reporting arrangements do not provide management and the Board with appropriate assurances.</li> </ul> |                                  |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                              | Priority                                                                                                                                                                                            |                                  |
| 1.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Reporting and committee structure should be reviewed and agreed to ensure there are appropriate governance arrangements in place to receive assurance on fire safety.                        | High                                                                                                                                                                                                |                                  |
| 1.1b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Fire safety reporting groups and committees should meet at regular intervals as per their agreed terms of reference. Any issues with attendance should be escalated to the relevant director |                                                                                                                                                                                                     |                                  |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                              | Target Date                                                                                                                                                                                         | Responsible Officer              |
| 1.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Reporting structure to be reviewed and align with escalation processes set out within the Health Board                                                                                       | 10/04/2025<br>29/10/2024                                                                                                                                                                            | Director of Corporate Governance |



|      |                                                                                                                       |  |                                                                     |
|------|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|
| 1.1b | Meeting to take place in accordance with the Terms of Reference of the Strategic Occupational Health and Safety Group |  | Chief Executive (in absence of Director of Environment and Estates) |
|------|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|

| Matter Arising 2: Policy for the Management of Fire Safety (Design)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                        |             | Impact                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The Policy for the Management of Fire Safety (ES04) is overdue for review (April 2022) and as such it does not reflect current management structure and existing governance arrangements.</p> <p>Estates advised the policy is under review and on hold in line with all Operational Estates policies until the appointment of the Director of the Environment. Once agreed it will be presented to the Strategic Occupational Health and Safety Group (SOHSG) for approval and ratified through the Quality Safety and Experience Committee.</p> <p>We have not been given a specific date as to when this would be completed.</p> |                                                                                                                                                                                                                                                                        |             | <p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Out of date policy may lead to non-compliance with statutory regulations</li> </ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |             | Priority                                                                                                                                             |
| 2.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy. |             | <b>Medium</b>                                                                                                                                        |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                        | Target Date | Responsible Officer                                                                                                                                  |
| 2.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.                                                               | 20/03/2025  | Head of Operational Estates                                                                                                                          |

| Matter Arising 3: Fire Risk Assessments (Operation)                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                          | Impact                                                                                                                                           |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| The number of outstanding / overdue FRA's across Health Board areas as in April 2024 was 189 or 26.4%, in some areas risk assessments were last completed in 2020 and 2021. This was confirmed during site visits where risk assessments in two sites were not up to date and required reviewing. |                                                                                                                                                                                                                                                                                                                                                          | Potential risk of: <ul style="list-style-type: none"> <li>Areas are not adequately assessed or prepared should a fire incident occur.</li> </ul> |                             |
| Recommendations                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                          | Priority                                                                                                                                         |                             |
| 3.1a                                                                                                                                                                                                                                                                                              | All officers accountable for Fire Risk Assessments ensure documents are reviewed and updated at regular intervals to ensure potential and new risks have been identified and evaluated. This should be monitored and escalated via the Fire Safety Management Group.                                                                                     | Medium                                                                                                                                           |                             |
| Agreed Management Action                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                          | Target Date                                                                                                                                      | Responsible Officer         |
| 3.1a                                                                                                                                                                                                                                                                                              | Fire Safety Advisors to ensure Fire Risk Assessments are undertaken within the recognised timeframes contained within HTM05-03: Operational provisions Part K - Guidance on fire risk assessments in complex healthcare premises. Reports will be generated and presented to the Fire Safety Management Group. Results will be escalated as appropriate. | 26/03/2025                                                                                                                                       | Head of Operational Estates |

| Matter Arising 4: Fire Training (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                           | Impact                                                                                                                                                                  |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Mandatory fire training is delivered face to face or through Teams and is recorded on individuals ESR, however Estates advised this is not reported centrally. A sample of five random staff members was selected to test compliance against training requirements as stated in Table 1 of the Fire Safety policy – none of them show compliance against defined requirements. We noted 671 staff have received Fire Warden Training since 13 September 2021 to 29 May 2024 inclusive, however we are unable to determine whether they have received annual training per the 'Target Audience' requirement for their role. |                                                                                                                                                                                                                                                                                                                                                                           | Potential risk of: <ul style="list-style-type: none"> <li>Inadequate/irregular training may lead to staff not aware of actions to take in the event of fire.</li> </ul> |                             |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                           | Priority                                                                                                                                                                |                             |
| 4.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.                                                                        | High                                                                                                                                                                    |                             |
| Agreed Management Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                           | Target Date                                                                                                                                                             | Responsible Officer         |
| 4.1a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly.<br><br>Training needs analysis will be reviewed against the new HTM o5-03 Part A. | 20/03/2025                                                                                                                                                              | Head of Operational Estates |

| Matter Arising 5: Annual Management Fire Audit (Operation)                                                                                                    |                                                                                                                                                                                                                                 |                                                               | Impact                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The report for the last annual management fire audit was submitted outside the recognised timeframe. We have not been able to verify evidence for submission. |                                                                                                                                                                                                                                 |                                                               | Potential risk of: <ul style="list-style-type: none"> <li>Non-compliance with statutory regulations.</li> <li>Benefits of the audit may not be recognised and achieved.</li> </ul> |
| Recommendations                                                                                                                                               |                                                                                                                                                                                                                                 |                                                               | Priority                                                                                                                                                                           |
| 5.1a                                                                                                                                                          | Management ensure compliance with the requirement of Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety, and annual management fire audit be submitted within the mandatory timeframes. | High                                                          |                                                                                                                                                                                    |
| Agreed Management Action                                                                                                                                      |                                                                                                                                                                                                                                 | Target Date                                                   | Responsible Officer                                                                                                                                                                |
| 5.1a                                                                                                                                                          | Fire Safety Audit to be conducted as detailed in WHTM05/01 Managing Healthcare Fire Safety utilising the Fire Safety Audit System. The outcomes communicated to the Board via the escalation process through the SOHSG          | 06/08/2024<br>(Completed)<br><i>Audit note – not verified</i> | Head of Operational Estates                                                                                                                                                        |

| Matter Arising 6: Site Specific Issues / Documentation (Operation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Impact                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>A number of issues were identified through our testing at Health Board sites. These are detailed at Appendix C. The key areas for improvement include:</p> <ul style="list-style-type: none"><li>• List of fire wardens were not locally displayed in four sites.</li><li>• At two sites it was noted that fire action notices do not indicate where the nearest fire alarm point is (left blank).</li><li>• Estates advised that due to delays within the tendering process there are some areas where Fire Fighting equipment FFE is overdue for servicing. An external company who were awarded the contract are currently undertaking a servicing programme to test all outstanding FFE. This was evidenced at one of the hospital sites visited, all equipment were out of date and last inspected January 2023 with a couple of fire extinguishers last inspected in November 2017.</li><li>• At Chirk Community Hospital there is one hydrant to the rear of the building but there are no up to date test records available within Operational Estates. North Wales Fire and Rescue Service confirmed that the hydrant is on a branch main under the control of BCUHB. Operational Estates will have the hydrant tested and included on a maintenance regime.</li><li>• A regime for the testing of fire doors across the Health Board does not exist at the moment.</li><li>• At one community hospital site we were provided with a Fire Detection &amp; Alarm System Inspection and Servicing Certificate, but this was dated February 2023, also a Smoke Damper Test Certificate was dated October 2022 – no further inspections since.</li><li>• In all sites fire evacuation drills have not been undertaken for a number of years, only recently those have been completed in some hospital sites.</li></ul> | <p>Potential risk of:</p> <ul style="list-style-type: none"><li>• Non-compliance with statutory regulations and Health Board policy.</li></ul> |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Priority                                                                                                                                       |

| 6.1a                     | Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion. | High        |                             |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------|
| Agreed Management Action |                                                                                                                                                                                                       | Target Date | Responsible Officer         |
| 6.1a                     | Action plan has been generated to address the issues raised in Appendix C of this report and progress on resolving the findings will be reported to the Fire Safety Management Group.                 | 20/03/2025  | Head of Operational Estates |
|                          | Review the current arrangements for the undertaking of pre-planned maintenance and present the findings and recommendations to the Fire Safety Management Group.                                      | 20/03/2025  | Head of Operational Estates |
|                          | Report the number and results of Fire Drills to the Fire Safety Management Group.                                                                                                                     | 27/11/2024  | Head of Operational Estates |
|                          | Review the current arrangements for the undertaking of Fire drills across BCUHB and present the findings and recommendations to the Fire Safety Management Group.                                     | 27/11/2024  | Head of Operational Estates |

## 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:

|  |                                 |                                                                                                                                                                                                                                                            |
|--|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>Substantial assurance</b>    | Few matters require attention and are compliance or advisory in nature.<br><b>Low impact</b> on residual risk exposure.                                                                                                                                    |
|  | <b>Reasonable assurance</b>     | Some matters require management attention in control design or compliance.<br><b>Low to moderate impact</b> on residual risk exposure until resolved.                                                                                                      |
|  | <b>Limited assurance</b>        | More significant matters require management attention.<br><b>Moderate impact</b> on residual risk exposure until resolved.                                                                                                                                 |
|  | <b>Unsatisfactory assurance</b> | Action is required to address the whole control framework in this area.<br><b>High impact</b> on residual risk exposure until resolved.                                                                                                                    |
|  | <b>Assurance not applicable</b> | Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.<br>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.<br>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.<br>Some risk to achievement of a system objective.                                                          | Within one month*    |
| Low            | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>Generally issues of good practice for management consideration.              | Within three months* |

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



## Appendix C – Detailed site findings

| Hospital Site                                            | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tywyn Community Hospital - Outpatients                   | <ul style="list-style-type: none"> <li>List of Fire Warden Names is not locally displayed – Tywyn Fire warden advised this will be displayed in staff areas once list has been received.</li> <li>The latest fire drills were completed in March 2024. Prior to this, and for several years fire drills did not take place.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Chirk Community Hospital - Care of the Elderly Ward      | <ul style="list-style-type: none"> <li>There is one hydrant to the rear of the building but there are no up to date test records available within Operational Estates. North Wales Fire and Rescue Service confirmed that the hydrant is on a branch main under the control of the Health Board. Operational Estates will have the hydrant tested and included on a maintenance regime.</li> <li>The latest fire drills were completed in June 2024. Prior to this and for several years fire drills did not take place.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Holywell Community Hospital - Care of the Elderly Ward A | <ul style="list-style-type: none"> <li>List of Fire Warden Names is not locally displayed.</li> <li>Fire Action Notices do not show where is the nearest fire alarm point (left blank).</li> <li>Fire Risk Assessments for Plant and Storerooms, those were last completed 23/1/23. Day Hospital, Day Support Unit, Therapies, Outpatients, X-Ray, Dental Health Clinic, Medical Practitioners and Minor Injury Unit those were last completed 23/11/22.</li> <li>Latest Fire Detection &amp; Alarm System Inspection and Servicing Certificate, was dated 10/2/2023 – no further inspection since.</li> <li>All equipment were out of date - last inspected January 2023 in Ward A and in Managers Corridors there were a couple of Fire Extinguishers that were last inspected in November 2017.</li> <li>Latest Fire Extinguishers Inspection Certificate, was dated 27/1/2023 – no further inspection since.</li> <li>The latest fire drills were completed in June 2024. Prior to this and for several years fire drills did not take place.</li> <li>Estates provided the latest Fire / Smoke Damper Test Certificate, this was dated 10/2/2022 – no further inspection since.</li> </ul> |
| Ysbyty Gwynedd - Theatres                                | <ul style="list-style-type: none"> <li>The latest fire drills were completed in April 2024. Prior to this and for several years fire drills did not take place.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Wrexham Maelor Hospital - Outpatients                    | <ul style="list-style-type: none"> <li>Outpatients has two identified fire wardens but this is not displayed.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                         |                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         | <ul style="list-style-type: none"><li>• Fire Action Notices do not show where is the nearest fire alarm point (left blank).</li><li>• Recent evacuation drill was completed in April 2024 in Theatre A. Further evacuation drill planned for modular theatres in Aug 2024. Prior to this and for several years fire drills did not take place.</li></ul> |
| Abergele Hospital - Ward 6 Orthopaedics | <ul style="list-style-type: none"><li>• List of Fire Warden Names is not locally displayed.</li><li>• Fire Risk Assessments for all wards and areas were last completed October 2022.</li><li>• Fire drills are planned for December 2024. Prior to this and for several years fire drills did not take place.</li></ul>                                 |
| All                                     | <ul style="list-style-type: none"><li>• Estates advised that a regime for the testing of fire doors across Health Board sites does not exist at the moment. This has been recognised and they are looking at options to address this matter including outsourcing to an external provider.</li></ul>                                                     |



GIG  
CYMRU  
NHS  
WALES

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

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](#)

# Review Title

## Draft Internal Audit Report 2024/25

XXX University Health Board/NHS Trust



Reasonable Assurance

### Contents

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### Review Reference

XXX-2425-XX

### Fieldwork

XX July 2024

### Executive Sign Off

XX August 2024

### Audit Committee

September 2024

### Executive Lead

### Head of Internal Audit

### Deputy Head of Internal Audit

# Executive Summary

## Purpose

From brief / IA plan, high level e.g. To review the effectiveness of the governance arrangements within the service.

## Background

We have concluded **substantial / reasonable / limited / unsatisfactory** assurance on this area. **We have identified no matters for reporting in our review. OR**  
**The [significant] matters requiring management attention include:**

- 1
- 2
- 3
- 4
- 5
- 6

Full details of matters arising are detailed within the Findings & Agreed Action Plan. **The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information: [DELETE IF N/A]**

- xxx

## Scope & Assurance Summary

| Objectives |                                         | Related Findings | Assurance      |
|------------|-----------------------------------------|------------------|----------------|
| 1          | Full objective description as per brief | -                | Substantial    |
| 2          | Full objective description as per brief | 1                | Reasonable     |
| 3          | Full objective description as per brief | 2, 3             | Limited        |
| 4          | Full objective description as per brief | 4, 5             | Unsatisfactory |

## Summary of Management Actions

| 2               |                 | 3               |                 |                                                                                                |   |
|-----------------|-----------------|-----------------|-----------------|------------------------------------------------------------------------------------------------|---|
| High Priority   |                 | Medium Priority |                 |                                                                                                |   |
| Choose an item. | Choose an item. | Choose an item. | Choose an item. | Control <b>Design</b> Issues: Inadequate or poorly designed controls that do not address risks | X |
| Choose an item. | Choose an item. | Choose an item. | Choose an item. |                                                                                                |   |
| Choose an item. | Choose an item. | Choose an item. | Choose an item. |                                                                                                |   |
| Choose an item. | Choose an item. | Choose an item. | Choose an item. | Control <b>Operation</b> Issues: Controls that are not executed correctly or consistently      | X |
| Choose an item. | Choose an item. | Choose an item. | Choose an item. |                                                                                                |   |

[Service/area/topic name] - At a Glance [optional – agree with DHIA before completing this page]

# Findings & Agreed Action Plan

|                    |             |
|--------------------|-------------|
| Objective 1: xxxxx | Substantial |
|--------------------|-------------|

Overview / Summary of Observations [MAX 200 WORDS]

| Key Findings |                                                                                | Risk & Impact     | Agreed Management Action             |
|--------------|--------------------------------------------------------------------------------|-------------------|--------------------------------------|
| 1            | Matter Arising Title [as per ESRA]<br>xxxxxxxxxxxxxxxxxxxxx<br>[MAX 100 WORDS] |                   | Agreed Action:                       |
|              |                                                                                |                   | Expected Evidence of Implementation: |
|              |                                                                                | High Priority     | Officer:                             |
|              | Theme: Choose an item.                                                         | Control Design    | Date:                                |
| 2            | Matter Arising Title [as per ESRA]<br>xxxxxxxxxxxxxxxxxxxxx<br>[MAX 100 WORDS] |                   | Agreed Action:                       |
|              |                                                                                |                   | Expected Evidence of Implementation: |
|              |                                                                                | Medium Priority   | Officer:                             |
|              | Theme: Choose an item.                                                         | Control Operation | Date:                                |



|   |                                                                                                    |                 |                                      |
|---|----------------------------------------------------------------------------------------------------|-----------------|--------------------------------------|
| 3 | <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|   |                                                                                                    |                 | Expected Evidence of Implementation: |
|   |                                                                                                    | Choose an item. | Officer:                             |
|   | Theme: Choose an item.                                                                             | Choose an item. | Date:                                |
| 4 | <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|   |                                                                                                    |                 | Expected Evidence of Implementation: |
|   |                                                                                                    | Choose an item. | Officer:                             |
|   | Theme: Choose an item.                                                                             | Choose an item. | Date:                                |
| 5 | <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|   |                                                                                                    |                 | Expected Evidence of Implementation: |
|   |                                                                                                    | Choose an item. | Officer:                             |
|   | Theme: Choose an item.                                                                             | Choose an item. | Date:                                |

Overview / Summary of Observations [MAX 200 WORDS]

| Key Findings |                                                                                | Risk & Impact   | Agreed Management Action             |
|--------------|--------------------------------------------------------------------------------|-----------------|--------------------------------------|
| 6            | Matter Arising Title [as per ESRA]<br>xxxxxxxxxxxxxxxxxxxxx<br>[MAX 100 WORDS] |                 | Agreed Action:                       |
|              |                                                                                |                 | Expected Evidence of Implementation: |
|              |                                                                                | Choose an item. | Officer:                             |
|              | Theme: Choose an item.                                                         | Choose an item. | Date:                                |
| 7            | Matter Arising Title [as per ESRA]<br>xxxxxxxxxxxxxxxxxxxxx<br>[MAX 100 WORDS] |                 | Agreed Action:                       |
|              |                                                                                |                 | Expected Evidence of Implementation: |
|              |                                                                                | Choose an item. | Officer:                             |
|              | Theme: Choose an item.                                                         | Choose an item. | Date:                                |

|                                                                                                    |                 |                                      |
|----------------------------------------------------------------------------------------------------|-----------------|--------------------------------------|
| <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|                                                                                                    |                 | Expected Evidence of Implementation: |
|                                                                                                    | Choose an item. | Officer:                             |
| Theme: Choose an item.                                                                             | Choose an item. | Date:                                |

|                                                                                                    |                 |                                      |
|----------------------------------------------------------------------------------------------------|-----------------|--------------------------------------|
| <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|                                                                                                    |                 | Expected Evidence of Implementation: |
|                                                                                                    | Choose an item. | Officer:                             |
| Theme: Choose an item.                                                                             | Choose an item. | Date:                                |

|                                                                                                    |                 |                                      |
|----------------------------------------------------------------------------------------------------|-----------------|--------------------------------------|
| <b>Matter Arising Title</b> <i>[as per ESRA]</i><br>xxxxxxxxxxxxxxxxxxxx<br><b>[MAX 100 WORDS]</b> |                 | Agreed Action:                       |
|                                                                                                    |                 | Expected Evidence of Implementation: |
|                                                                                                    | Choose an item. | Officer:                             |
| Theme: Choose an item.                                                                             | Choose an item. | Date:                                |

Overview / Summary of Observations [MAX 200 WORDS]

| Key Findings                                                                                             | Risk & Impact                      | Agreed Management Action             |
|----------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------|
| <div>Matter Arising Title [as per ESRA]</div> <div>xxxxxxxxxxxxxxxxxxxx</div> <div>[MAX 100 WORDS]</div> |                                    | Agreed Action:                       |
|                                                                                                          |                                    | Expected Evidence of Implementation: |
|                                                                                                          | Choose an item.<br>Choose an item. | Officer:<br>Date:                    |
| Theme: Choose an item.                                                                                   |                                    |                                      |
| <div>Matter Arising Title [as per ESRA]</div> <div>xxxxxxxxxxxxxxxxxxxx</div> <div>[MAX 100 WORDS]</div> |                                    | Agreed Action:                       |
|                                                                                                          |                                    | Expected Evidence of Implementation: |
|                                                                                                          | Choose an item.<br>Choose an item. | Officer:<br>Date:                    |
| Theme: Choose an item.                                                                                   |                                    |                                      |

|                                                                                                             |                                    |                                      |
|-------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------|
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>xxxxxxxxxxxxxxxxxxxxx</p> <p>[MAX 100 WORDS]</p> |                                    | Agreed Action:                       |
|                                                                                                             |                                    | Expected Evidence of Implementation: |
|                                                                                                             | Choose an item.<br>Choose an item. | Officer:<br>Date:                    |
| <p><b>Theme:</b> Choose an item.</p>                                                                        |                                    |                                      |
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>xxxxxxxxxxxxxxxxxxxxx</p> <p>[MAX 100 WORDS]</p> |                                    | Agreed Action:                       |
|                                                                                                             |                                    | Expected Evidence of Implementation: |
|                                                                                                             | Choose an item.<br>Choose an item. | Officer:<br>Date:                    |
| <p><b>Theme:</b> Choose an item.</p>                                                                        |                                    |                                      |
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>xxxxxxxxxxxxxxxxxxxxx</p> <p>[MAX 100 WORDS]</p> |                                    | Agreed Action:                       |
|                                                                                                             |                                    | Expected Evidence of Implementation: |
|                                                                                                             | Choose an item.<br>Choose an item. | Officer:<br>Date:                    |
| <p><b>Theme:</b> Choose an item.</p>                                                                        |                                    |                                      |

Overview / Summary of Observations [MAX 200 WORDS]

| Key Findings                                                                                             |                 | Risk & Impact   | Agreed Management Action             |
|----------------------------------------------------------------------------------------------------------|-----------------|-----------------|--------------------------------------|
| <div>Matter Arising Title [as per ESRA]</div> <div>xxxxxxxxxxxxxxxxxxxx</div> <div>[MAX 100 WORDS]</div> |                 |                 | Agreed Action:                       |
|                                                                                                          |                 |                 | Expected Evidence of Implementation: |
| Theme: Choose an item.                                                                                   | Choose an item. | Choose an item. | Officer:<br>Date:                    |
| <div>Matter Arising Title [as per ESRA]</div> <div>xxxxxxxxxxxxxxxxxxxx</div> <div>[MAX 100 WORDS]</div> |                 |                 | Agreed Action:                       |
|                                                                                                          |                 |                 | Expected Evidence of Implementation: |
| Theme: Choose an item.                                                                                   | Choose an item. | Choose an item. | Officer:<br>Date:                    |

|                                                                                                            |                        |                                             |
|------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------|
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>XXXXXXXXXXXXXXXXXXXX</p> <p>[MAX 100 WORDS]</p> |                        | <p>Agreed Action:</p>                       |
|                                                                                                            |                        | <p>Expected Evidence of Implementation:</p> |
| <p><b>Theme:</b> Choose an item.</p>                                                                       | <p>Choose an item.</p> | <p>Officer:</p> <p>Date:</p>                |
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>XXXXXXXXXXXXXXXXXXXX</p> <p>[MAX 100 WORDS]</p> |                        | <p>Agreed Action:</p>                       |
|                                                                                                            |                        | <p>Expected Evidence of Implementation:</p> |
| <p><b>Theme:</b> Choose an item.</p>                                                                       | <p>Choose an item.</p> | <p>Officer:</p> <p>Date:</p>                |
| <p><b>Matter Arising Title</b> <i>[as per ESRA]</i></p> <p>XXXXXXXXXXXXXXXXXXXX</p> <p>[MAX 100 WORDS]</p> |                        | <p>Agreed Action:</p>                       |
| <p><b>Theme:</b> Choose an item.</p>                                                                       | <p>Choose an item.</p> | <p>Expected Evidence of Implementation:</p> |
|                                                                                                            |                        | <p>Officer:</p> <p>Date:</p>                |



# Appendix A

## Assurance Opinion

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

### Prioritisation of Findings

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

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

## Disclaimer

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

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

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

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

## Public Sector Internal Audit Standards

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



# Draft Internal Audit Plan 2024/25 – October 2024 to March 2025

October 2024

Betsi Cadwaladr University Health Board



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



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



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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 Chartered Institute of Public Finance & Accountancy in April 2023.

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# 1. Introduction

The Audit Committee approved the six-month Internal Audit Plan for the Health Board, covering April – September 2024 and the Internal Audit Charter in March 2024.

This document sets out the plan for the second half of the year, covering October 2024 to March 2025 (the Plan), and details the audits to be undertaken and an analysis of the corresponding resources.

We have not included details of the planning process within this document, as these were included in the plan approved by Audit Committee in March 2024.

# 2. Planned internal audit coverage

## 2.1 Internal Audit Plan 2024/25 (October 2024 to March 2025)

The six-month Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register, related systems of assurance and outline scope. The scope, objectives and timing will be refined when developing the audit brief in discussion with the responsible executive director(s) and operational management.

The Audit Committee will be kept apprised of performance in delivery of the Plan through routine progress reports to each Audit Committee meeting.

The audit work will be undertaken by our regionally based team with support from our national Capital & Estates team, in terms of capital audit and from our Digital & IT team regarding Information Governance, IT security and digital work.

## 2.2 Keeping the plan under review

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

The development of a six-month plan ensures we can focus on priority risk areas, business critical systems, and the provision of assurance to management across the year ahead. We will, as always, keep the plan under review to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan enabling us to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

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

### 3. Resource needs assessment

The plan has been put together on the basis of the planning process described in the plan approved in March 2024. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

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

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

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

### 4. Action required

The Audit Committee is invited to consider the Internal Audit Plan for October 2024 to March 2025 and:

- approve the six-month Internal Audit Plan for October 2024 to March 2025; and
- note the Audit Universe/Rolling plan and the risks identified for consideration for 2025/26.

Dave Harries CMIIA QiCA

Head of Internal Audit – Betsi Cadwaladr University Local Health Board

Audit & Assurance Services

NHS Wales Shared Services Partnership

## Appendix A: Internal Audit Plan 2024/25 – October 2024 to March 2025

| Planned output, Outline scope, Review reference                                                                                                                                                                   | Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale | Executive/ Responsible Director  | Planned start   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------|-----------------|
| Corporate Governance and Regulatory                                                                                                                                                                               |                                                                              |                                  |                 |
| <b>Board Assurance Framework &amp; Risk Management</b><br>We will review the efficacy of the Health Board's Risk Management and Board Assurance processes.                                                        | SP 1                                                                         | Director of Corporate Governance | January 2025    |
| <b>Standards of Business Conduct - Declarations of interest, gifts, and hospitality</b><br>We will review the processes in place to comply with Standing Orders (Order 8): Values and Standards of Behaviour.     | SP 1                                                                         | Director of Corporate Governance | February 2025   |
| <b>Follow-Up of Internal Audit recommendations</b><br>We will review the implementation of Limited assurance report recommendations not subject to full review and those defined as 'High Risk' in other reviews. | Public sector Internal Audit Standards compliance                            | Director of Corporate Governance | October - March |
| Strategic                                                                                                                                                                                                         |                                                                              |                                  |                 |

| Planned output, Outline scope, Review reference                                                                                                                                                                                                                                          | Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale | Executive/ Responsible Director                                                                                               | Planned start |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------|
| <b>Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)</b><br>We will assess implementation of the management actions agreed because of the no assurance review in 2022/23.                                                                 | SP 2<br>CRR 24-11                                                            | Executive Director of Nursing & Midwifery / Interim Executive Director of Finance / Director of Performance and Commissioning | January 2025  |
| <b>Performance management framework &amp; Reporting</b><br>We will review the implementation of, and confirm that, the Integrated Performance Framework (IPF) 2023-25 is operating as expected following Health Board approval in September 2023.                                        | SP 1                                                                         | Interim Executive Director of Finance / Director of Performance and Commissioning                                             | October 2024  |
| <b>Partnerships, Engagement and Communications</b><br>We will review progress made by the Health Board in implementing its Strategy for 2022-2025 along with review of actions emanating from Special Measures and internally commissioned reviews that focus on stakeholder engagement. | SP 1                                                                         | Director of Partnerships, Communications and Engagement                                                                       | October 2024  |
| Financial                                                                                                                                                                                                                                                                                |                                                                              |                                                                                                                               |               |
| <b>Budgetary Control &amp; Financial reporting</b>                                                                                                                                                                                                                                       | SP 2<br>CRR 24-05                                                            | Interim Executive Director of Finance                                                                                         | February 2025 |

| Planned output, Outline scope, Review reference                                                                                                                            | Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale | Executive/ Responsible Director                      | Planned start |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------|---------------|
| We will review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders. |                                                                              |                                                      |               |
| <b>Standing Financial Instructions – Procurement</b>                                                                                                                       | SP 2                                                                         | Interim Executive Director of Finance                | November 2024 |
| We will undertake a review of progress against the agreed Special Measures action plan for procurement.                                                                    |                                                                              |                                                      |               |
| Clinical governance, Quality and Safety                                                                                                                                    |                                                                              |                                                      |               |
| <b>Clinical Audit</b>                                                                                                                                                      | SP 4                                                                         | Executive Medical Director / Chief Operating Officer | November 2024 |
| We will review operational compliance with Health Board Policy, review and sharing of audit findings and delivery of Tier 1, Tier 2 and Tier 3 audits.                     | CRR 24-04                                                                    |                                                      |               |
| Technology                                                                                                                                                                 |                                                                              |                                                      |               |
| No risks identified for October 2024 – March 2025                                                                                                                          |                                                                              |                                                      |               |
| Operational service and Functional management                                                                                                                              |                                                                              |                                                      |               |
| <b>Effective Governance: Integrated Health Community – East</b>                                                                                                            | SP 4                                                                         | Chief Operating Officer                              | October 2024  |
| We will review the effectiveness of governance arrangements within the IHC.                                                                                                | CRR 24-16                                                                    |                                                      |               |



| Planned output, Outline scope, Review reference                                                                                                                                                                                                                                                                                                                                                                       | Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale | Executive/ Responsible Director                             | Planned start  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------|----------------|
| <b>Effective Governance: Cancer Services</b><br>We will review the effectiveness of governance arrangements within the service.                                                                                                                                                                                                                                                                                       | SP 4<br>CRR 24-16                                                            | Chief Operating Officer                                     | November 2024  |
| Workforce management                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                              |                                                             |                |
| <b>Consultant Job Planning</b><br>We will review compliance with the <i>Amendment to the National Consultant Contract in Wales</i> paying particular focus on the job planning process.<br>We will consider whether there is dedicated specialist support and advice available in respect of medical & dental staff working across the Health Board, recognising they have different Terms and Conditions of service. | SP 1<br>CRR 24-01                                                            | Executive Medical Director / Deputy Director of People & OD | October 2024   |
| <b>Job evaluation</b><br>We will assess how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the Health Board.                                                                                                                                                                                                                                                                    | SP 1<br>CRR 24-01                                                            | Deputy Director of People & OD                              | November 2024  |
| Project/Programme                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                             |                |
| <b>Integrated Assurance and Approval Plans (IAAP)</b><br>The following programme/project audits are scheduled to be progressed during 2024/25 (but will also be subject to any audit planning updates                                                                                                                                                                                                                 | SP 2<br>CRR 24-06                                                            | Interim Executive Director of Finance                       | April to March |

| Planned output, Outline scope, Review reference                                                                                                                                                                                                                                                 | Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale | Executive/ Responsible Director       | Planned start |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------|---------------|
| required at respective SOC/OBC/FBC submissions):                                                                                                                                                                                                                                                |                                                                              |                                       |               |
| <ul style="list-style-type: none"> <li>• Llandudno Hospital Orthopaedic Hub</li> <li>• Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit</li> <li>• Ysbyty Maelor Wreccsam - Infrastructure/ Continuity Works</li> </ul>                                                           |                                                                              |                                       |               |
| Property                                                                                                                                                                                                                                                                                        |                                                                              |                                       |               |
| <b>Waste Management</b><br>We will review the Health Board's compliance with WHTM 07-01 Welsh Health Technical Memorandum Safe management of healthcare waste and ascertain how it is preparing for implementation of the Waste Separation Requirements (Wales) Regulations 2023 in April 2026. | CRR 24-06                                                                    | Interim Executive Director of Finance | January 2025  |

## Appendix B: Audit Universe/Rolling Plan

The review topics detailed is not an exhaustive list of all services/processes identified and some will reflect a whole system, upon which elements will be reviewed.

The ✓ in 2023/24 indicates we intend to provide assurance in this area. The R records an identified risk area for consideration as part of the next six-month plan (October to March). Due to the risk based approach and resources available, we will not undertake reviews in all those identified areas and the Committee/management may wish to ensure they have adequate second-line assurance reporting in place.

| Review topics                                                                     | 2019/ 20   | 2020/ 21   | 2021/ 22   | 2022/23 | 2023/24    | 2024/25                                                             | 2025/26              |
|-----------------------------------------------------------------------------------|------------|------------|------------|---------|------------|---------------------------------------------------------------------|----------------------|
| <b>ANNUAL OPINION</b>                                                             | Reasonable | Reasonable | Limited    | Limited | Limited    | ✓ = April - September<br>✓✓ October - March<br>Ⓡ = Risks identified | Ⓡ = Risks identified |
| <b>Corporate governance, risk, and regulatory compliance</b>                      |            |            |            |         |            |                                                                     |                      |
| Welsh Language Measure (Wales) 2011                                               | Limited    |            |            | Limited | Reasonable |                                                                     | Ⓡ                    |
| Board Assurance Framework & Risk Management                                       |            | Reasonable | Reasonable | Limited | Limited    | ✓✓                                                                  | Ⓡ                    |
| Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016         |            |            |            |         | Ⓡ          | Ⓡ                                                                   |                      |
| Corporate Legislative Compliance - Equality Act 2010: Public Sector Equality Duty |            |            |            |         |            | Ⓡ                                                                   |                      |

| Review topics                                                                                 | 2019/ 20          | 2020/ 21                   | 2021/ 22                   | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|-----------------------------------------------------------------------------------------------|-------------------|----------------------------|----------------------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                                                         | <b>Reasonable</b> | <b>Reasonable</b>          | <b>Limited</b>             | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Corporate Legislative Compliance: Social Services and Well-being (Wales) Act 2014             |                   |                            |                            |                |                |                                                                       |                        |
| COVID-19 Governance & Associated reviews                                                      |                   | Assurance not applicable*2 | Assurance not applicable*2 |                |                |                                                                       |                        |
| Corporate Legislative Compliance - Civil Contingencies Act 2004                               |                   |                            |                            |                |                | Deferred                                                              |                        |
| Partnership governance                                                                        | Limited           |                            | Limited                    |                | (R)            | (R)                                                                   |                        |
| Regional Partnership Board/Integrated Service Board                                           |                   |                            | Limited                    |                |                |                                                                       |                        |
| Standards of Business Conduct - Declarations of interest, gifts, and hospitality              |                   |                            | Limited                    |                | Limited        | ✓✓                                                                    | (R)                    |
| Board, Executive, Divisional Governance                                                       |                   | Limited                    | Assurance not applicable   | Limited        |                | (R)                                                                   |                        |
| Operating Model                                                                               |                   |                            |                            |                | Unsatisfactory |                                                                       |                        |
| Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation (SORD) |                   |                            |                            | Reasonable     | (R)            |                                                                       |                        |

| Review topics                                | 2019/ 20          | 2020/ 21                 | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|----------------------------------------------|-------------------|--------------------------|----------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                        | <b>Reasonable</b> | <b>Reasonable</b>        | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Policies & Procedures                        |                   |                          |                |                | (R)            | (R)                                                                   |                        |
| Targeted Intervention/Special Measures       |                   |                          | Reasonable     |                |                | ✓                                                                     |                        |
| Impact Assessments                           | Limited           |                          | Reasonable     |                |                |                                                                       |                        |
| Welsh Risk Pool – Claims Management          | Reasonable        | Substantial              |                |                |                |                                                                       |                        |
| Annual Report/Annual Governance Statement    | Advisory          | Advisory                 | Advisory       | Advisory       | Advisory       | Advisory                                                              | ✓                      |
| Preparations for EU Exit (BREXIT)            |                   | Assurance not applicable |                |                |                |                                                                       |                        |
| <b>Strategic risk</b>                        |                   |                          |                |                |                |                                                                       |                        |
| Performance management framework & Reporting |                   | Reasonable               |                | Limited        | (R)            | ✓✓                                                                    |                        |
| Strategic planning - Including IMTP          |                   |                          |                |                | (R)            |                                                                       |                        |
| Annual Operational Plan                      |                   |                          |                |                |                | (R)                                                                   |                        |
| Business Continuity Planning/Arrangements    |                   | Limited                  | Limited        |                |                | (R)                                                                   |                        |
| Healthcare Commissioning                     |                   |                          |                |                |                | (R)                                                                   |                        |

| Review topics                                                  | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23                  | 2023/24        | 2024/25                                                               | 2025/26                |
|----------------------------------------------------------------|-------------------|-------------------|----------------|--------------------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                          | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b>           | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Transformation / Project Management                            |                   |                   |                | Assurance not applicable |                | ✓                                                                     |                        |
| Communication, Partnerships and Stakeholder engagement         |                   |                   |                |                          | (R)            | ✓✓                                                                    |                        |
| <b>Financial risk</b>                                          |                   |                   |                |                          |                |                                                                       |                        |
| Asset management                                               |                   |                   |                |                          | (R)            |                                                                       |                        |
| Benefits Realisation                                           |                   |                   |                |                          | (R)            |                                                                       |                        |
| Budgetary Control & Financial reporting                        | Reasonable        | Reasonable        | Reasonable     | Reasonable               | Limited        | ✓✓                                                                    |                        |
| Business Case - Capital and Revenue                            |                   |                   |                |                          | (R)            | ✓                                                                     |                        |
| Accounts Receivable - Cash and Bank/Petty Cash/Cash receipting |                   |                   |                |                          | Reasonable     | (R)                                                                   |                        |
| Charitable Funds                                               |                   |                   |                | Limited                  | Deferred       | ✓                                                                     |                        |
| Costing                                                        |                   |                   |                |                          |                |                                                                       |                        |
| Counter Fraud                                                  |                   |                   |                | Reasonable               |                |                                                                       |                        |
| Financial planning/Sustainability                              |                   |                   |                |                          |                |                                                                       |                        |
| General Ledger                                                 |                   |                   |                |                          | (R)            | (R)                                                                   |                        |
| Lease Cars                                                     |                   |                   |                |                          |                | (R)                                                                   |                        |
| Losses and Special Payments                                    |                   |                   |                |                          | (R)            |                                                                       |                        |

| Review topics                                   | 2019/ 20                 | 2020/ 21                 | 2021/ 22       | 2022/23                  | 2023/24                             | 2024/25                                                               | 2025/26                |
|-------------------------------------------------|--------------------------|--------------------------|----------------|--------------------------|-------------------------------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                           | <b>Reasonable</b>        | <b>Reasonable</b>        | <b>Limited</b> | <b>Limited</b>           | <b>Limited</b>                      | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Standing Financial Instructions - Procurement   | Reasonable*2             |                          | Reasonable     |                          | Special Measures report<br>Advisory | ✓✓                                                                    | (R)                    |
| Private / Overseas Patients                     |                          |                          |                |                          | (R)                                 | (R)                                                                   |                        |
| Patients Monies and Property                    | Assurance not applicable | Assurance not applicable |                |                          |                                     |                                                                       |                        |
| Payment Card Industry Compliance                |                          |                          |                |                          |                                     | (R)                                                                   | (R)                    |
| Savings - Identification and Delivery           |                          | Limited                  |                | No                       | Limited                             | (R)                                                                   |                        |
| Stores                                          |                          |                          |                |                          |                                     | (R)                                                                   |                        |
| Value Based Healthcare                          |                          |                          |                | Assurance not applicable |                                     | Reasonable                                                            |                        |
| Year-end processes                              |                          |                          |                |                          | Reasonable                          |                                                                       |                        |
| <b>Clinical governance quality &amp; safety</b> |                          |                          |                |                          |                                     |                                                                       |                        |
| Annual Quality Statement                        | Reasonable               | Reasonable               |                |                          |                                     |                                                                       |                        |
| Clinical audit                                  |                          |                          | Limited        |                          | Limited                             | ✓✓                                                                    |                        |
| Clinical coding                                 |                          |                          |                |                          |                                     |                                                                       |                        |

| Review topics                                                                                      | 2019/ 20          | 2020/ 21                 | 2021/ 22                 | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|----------------------------------------------------------------------------------------------------|-------------------|--------------------------|--------------------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                                                              | <b>Reasonable</b> | <b>Reasonable</b>        | <b>Limited</b>           | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Clinical Commissioning - Quality & Safety                                                          |                   |                          |                          | No             | Deferred       | ✓✓                                                                    |                        |
| Corporate Legislative Compliance: Health and safety at Work etc. Act etc. Act 1974                 | Reasonable        | Assurance not applicable |                          |                | Limited        |                                                                       |                        |
| Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 |                   |                          |                          |                | (R)            | ✓                                                                     |                        |
| Deprivation of Liberty Safeguards (DOLS)                                                           | Limited           |                          |                          |                | Limited        |                                                                       |                        |
| Decontamination                                                                                    | Limited           |                          |                          |                |                | (R)                                                                   |                        |
| End of Life Care                                                                                   |                   |                          |                          |                |                | (R)                                                                   |                        |
| Follow-up Healthcare Inspectorate Wales                                                            |                   |                          | Assurance not applicable |                |                | (R)                                                                   |                        |
| HASCAS & Ockenden Follow-up                                                                        | Reasonable        | Reasonable               | Assurance not applicable |                |                |                                                                       |                        |
| Incident management                                                                                |                   |                          |                          |                |                |                                                                       |                        |
| Infection Prevention and Control                                                                   |                   |                          |                          |                | (R)            | (R)                                                                   |                        |



| Review topics                                                                                      | 2019/ 20          | 2020/ 21                 | 2021/ 22                 | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|----------------------------------------------------------------------------------------------------|-------------------|--------------------------|--------------------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                                                              | <b>Reasonable</b> | <b>Reasonable</b>        | <b>Limited</b>           | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Medical equipment and devices                                                                      |                   |                          |                          |                |                |                                                                       | (R)                    |
| Nutrition and Hydration                                                                            |                   |                          |                          |                |                | (R)                                                                   |                        |
| Patient experience                                                                                 |                   |                          |                          |                | (R)            | (R)                                                                   |                        |
| Patient Safety Notices etc                                                                         |                   | Reasonable               |                          |                |                |                                                                       | (R)                    |
| Public Health                                                                                      |                   |                          |                          | Reasonable     |                | (R)                                                                   |                        |
| Concerns/Complaints/Putting things right/Learning Lessons                                          |                   |                          | Reasonable               |                | Limited        | Deferred                                                              |                        |
| Quality Improvement Strategy                                                                       | Limited           |                          |                          |                | (R)            | (R)                                                                   |                        |
| Research and Development                                                                           |                   |                          |                          |                |                | (R)                                                                   |                        |
| Safeguarding                                                                                       | Substantial       |                          |                          |                |                | (R)                                                                   |                        |
| Security                                                                                           |                   | Limited                  | Assurance not applicable |                |                | (R)                                                                   |                        |
| Ward accreditation                                                                                 |                   |                          |                          |                | (R)            | (R)                                                                   |                        |
| World Health Organisation (WHO) Checklist/Local Safety Standards for Invasive Procedures (LocSSIP) |                   |                          |                          |                |                | (R)                                                                   |                        |
| <b>Technology</b>                                                                                  |                   |                          |                          |                |                |                                                                       |                        |
| Informatics governance                                                                             |                   | Assurance not applicable |                          |                |                |                                                                       |                        |

| Review topics                                                 | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|---------------------------------------------------------------|-------------------|-------------------|----------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                         | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Digital Strategy / Digital Operating model                    |                   |                   |                | Reasonable     | Reasonable     |                                                                       | (R)                    |
| Artificial Intelligence (AI) – Use of Robotics and automation |                   |                   |                |                |                |                                                                       | (R)                    |
| Digital readiness                                             |                   |                   |                |                |                | (R)                                                                   | (R)                    |
| Service Management (ITIL)                                     |                   |                   |                |                | (R)            | (R)                                                                   |                        |
| Access Controls                                               |                   |                   |                |                |                |                                                                       |                        |
| Identity and certificate management                           |                   |                   |                |                |                |                                                                       |                        |
| Cyber security                                                | Reasonable        |                   | Reasonable     |                | Substantial    | (R)                                                                   |                        |
| Change Control                                                |                   |                   |                |                |                |                                                                       |                        |
| Data analytics / Intelligence led organisation                |                   |                   |                | Limited        |                | ✓                                                                     |                        |
| Business process automation / robotics                        |                   |                   |                |                | (R)            |                                                                       |                        |
| IT equipment / end user device management                     |                   |                   |                |                | (R)            | (R)                                                                   |                        |
| IT infrastructure / network management (inc. NIS Directive)   |                   |                   | Reasonable     |                | (R)            | ✓                                                                     |                        |
| IT Projects                                                   |                   |                   |                |                | (R)            |                                                                       |                        |
| Software / system development                                 |                   |                   |                |                |                |                                                                       |                        |
| Disaster recovery and resilience                              |                   | Limited           |                |                |                | (R)                                                                   |                        |

| Review topics                                                    | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                             | 2025/26              |
|------------------------------------------------------------------|-------------------|-------------------|----------------|----------------|----------------|---------------------------------------------------------------------|----------------------|
| <b>ANNUAL OPINION</b>                                            | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>Ⓡ = Risks identified | Ⓡ = Risks identified |
| Cloud migration                                                  |                   |                   |                |                |                |                                                                     |                      |
| Medical records management, control, and access                  |                   |                   |                |                | Reasonable     | Ⓡ                                                                   |                      |
| Patient records & Digital Integration / digitisation             |                   |                   |                |                | Substantial    |                                                                     |                      |
| Safe Care                                                        |                   |                   |                |                |                |                                                                     |                      |
| Data quality                                                     |                   |                   |                |                |                |                                                                     |                      |
| Corporate Legislative Compliance: Freedom of information Act     |                   |                   |                |                |                | Ⓡ                                                                   | Ⓡ                    |
| GDPR                                                             | Reasonable        |                   |                |                |                |                                                                     |                      |
| Welsh IG Toolkit (inc. Caldicott)                                |                   | Substantial       |                | Substantial    |                |                                                                     |                      |
| Locally managed IT systems - Where control rests outside of DDaT |                   |                   |                |                | Ⓡ              | Ⓡ                                                                   |                      |
| Datix Web                                                        |                   |                   |                |                |                | Ⓡ                                                                   |                      |
| IRIS                                                             |                   |                   |                |                |                | Ⓡ                                                                   |                      |
| WOREQ2                                                           |                   |                   |                |                |                |                                                                     |                      |
| CWS                                                              |                   |                   |                |                |                |                                                                     |                      |
| E-expenses                                                       |                   |                   |                |                |                | Ⓡ                                                                   |                      |
| Electronic Staff Record                                          |                   |                   |                |                |                | Ⓡ                                                                   |                      |

| Review topics                                        | 2019/ 20          | 2020/ 21          | 2021/ 22                 | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|------------------------------------------------------|-------------------|-------------------|--------------------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b>           | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Wellsky Pharmacy Management System                   |                   |                   |                          |                | (R)            |                                                                       |                        |
| Oracle E-financials                                  |                   |                   |                          |                |                |                                                                       |                        |
| PACS & Radis                                         |                   |                   |                          |                |                |                                                                       |                        |
| Welsh Clinical Portal                                |                   |                   |                          |                |                |                                                                       |                        |
| Welsh Demographic Service                            |                   |                   |                          |                |                |                                                                       |                        |
| WPAS                                                 |                   |                   |                          |                |                | (R)                                                                   |                        |
| <b>Operational service and functional management</b> |                   |                   |                          |                |                |                                                                       |                        |
| Bereavement Services                                 |                   |                   |                          |                |                |                                                                       |                        |
| Integrated Health Community - Central                |                   |                   | Assurance not applicable |                | Limited        |                                                                       |                        |
| Integrated Health Community - East                   |                   |                   |                          | Limited        |                | ✓✓                                                                    |                        |
| Integrated Health Community - West                   |                   |                   |                          | Limited        |                |                                                                       | (R)                    |
| Cancer Services                                      |                   |                   |                          |                |                | ✓✓                                                                    |                        |
| Womens Services                                      |                   |                   | Reasonable               |                | Reasonable     |                                                                       |                        |
| North Wales Managed Clinical Services                |                   |                   |                          |                |                |                                                                       | (R)                    |

| Review topics                                                  | 2019/ 20                 | 2020/ 21          | 2021/ 22                 | 2022/23        | 2023/24        | 2024/25                                                             | 2025/26              |
|----------------------------------------------------------------|--------------------------|-------------------|--------------------------|----------------|----------------|---------------------------------------------------------------------|----------------------|
| <b>ANNUAL OPINION</b>                                          | <b>Reasonable</b>        | <b>Reasonable</b> | <b>Limited</b>           | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>Ⓡ = Risks identified | Ⓡ = Risks identified |
| Mental Health and Learning Disabilities                        | Assurance not applicable | Limited           | Assurance not applicable | Reasonable     | Limited        |                                                                     | Ⓡ                    |
| Cluster management and development                             |                          |                   | Reasonable               |                |                | Ⓡ                                                                   |                      |
| Clinical Trials                                                |                          |                   |                          |                |                |                                                                     |                      |
| Discharge / Patient Flow management                            |                          |                   |                          |                | Limited        |                                                                     |                      |
| Continuing Health Care                                         |                          |                   |                          | Reasonable     |                | Ⓡ                                                                   |                      |
| Education                                                      |                          |                   |                          |                |                |                                                                     |                      |
| Emergency Medical Retrieval and Transfer Service Cymru (EMRTS) |                          |                   |                          |                |                |                                                                     |                      |
| Energy                                                         |                          |                   |                          |                |                |                                                                     |                      |
| Falls Management                                               |                          |                   |                          |                | Limited        | Ⓡ                                                                   |                      |
| General Dental Services                                        |                          |                   |                          |                |                |                                                                     | Ⓡ                    |
| General Medical Services                                       |                          |                   |                          |                |                | Ⓡ                                                                   |                      |
| General Ophthalmic Services                                    |                          |                   |                          |                |                |                                                                     |                      |
| GP Out of Hours                                                |                          |                   |                          |                | Limited        |                                                                     |                      |
| Urgent Primary Care Centres (UPCC)                             |                          |                   |                          | Limited        |                | Ⓡ                                                                   |                      |
| Looked After Children (LAC)                                    |                          |                   |                          |                |                | Ⓡ                                                                   |                      |

| Review topics                                  | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|------------------------------------------------|-------------------|-------------------|----------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                          | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Managed GP Practices                           | Reasonable        |                   |                |                | (R)            | (R)                                                                   |                        |
| Medical Physics                                |                   |                   |                |                |                |                                                                       |                        |
| Non-Emergency Patient Transport Service        | Reasonable        |                   |                |                |                |                                                                       |                        |
| Operational Estates and Facilities             |                   |                   |                |                |                | (R)                                                                   |                        |
| Primary Care – Transformation Fund/Other       |                   |                   |                |                |                |                                                                       |                        |
| Transport Management                           |                   |                   |                |                |                | (R)                                                                   |                        |
| Unscheduled care – Six Goals for Improvement   |                   |                   |                |                | (R)            | (R)                                                                   |                        |
| Waiting list management                        |                   |                   | Limited        |                | (R)            | (R)                                                                   |                        |
| Planned care delivery                          |                   |                   |                | Limited        |                | (R)                                                                   | (R)                    |
| Prison Healthcare Services                     |                   |                   |                |                |                |                                                                       |                        |
| NHS Wales Act - Section 33 Agreements          | Limited           |                   |                |                |                | (R)                                                                   |                        |
| Veterans                                       |                   |                   |                |                |                |                                                                       |                        |
| <b>Workforce management</b>                    |                   |                   |                |                |                |                                                                       |                        |
| Agency Staffing/IR35                           |                   | Limited           |                |                | (R)            |                                                                       |                        |
| Annual leave                                   |                   |                   |                |                |                |                                                                       |                        |
| Approved Clinicians and Section 12(2) approval |                   | Reasonable        |                |                |                |                                                                       |                        |

| Review topics                                                                                                               | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|----------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                                                                                       | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Case Management & Disciplinary process                                                                                      |                   |                   |                |                |                | ✓                                                                     |                        |
| Corporate Legislative Compliance: National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 |                   |                   |                |                | Reasonable     |                                                                       |                        |
| Consultant Contract/Job planning                                                                                            |                   |                   |                |                |                | ✓✓                                                                    |                        |
| Consultant Revalidation                                                                                                     |                   |                   |                |                |                | (R)                                                                   |                        |
| Staff Benefit Schemes                                                                                                       |                   |                   |                |                |                |                                                                       |                        |
| Roster management                                                                                                           |                   | Limited           | Limited        |                | (R)            | (R)                                                                   |                        |
| Job evaluation                                                                                                              |                   |                   |                |                |                | ✓✓                                                                    |                        |
| Manual Handling                                                                                                             |                   |                   |                |                |                | (R)                                                                   |                        |
| Medical Staffing                                                                                                            |                   |                   | Reasonable     |                |                |                                                                       |                        |
| NHS Wales Staff Survey                                                                                                      | Limited           |                   |                |                |                | (R)                                                                   |                        |
| Occupational Health                                                                                                         |                   |                   |                |                |                | (R)                                                                   |                        |
| On-Call                                                                                                                     |                   |                   | Limited        |                |                | (R)                                                                   |                        |
| Payroll/Salary Overpayments                                                                                                 | Limited           |                   |                |                |                |                                                                       |                        |
| PADRs                                                                                                                       |                   |                   |                |                |                |                                                                       |                        |
| People & OD Strategy                                                                                                        |                   |                   |                |                | Deferred       | Deferred                                                              |                        |
| Professional Registration                                                                                                   |                   |                   |                |                | (R)            | (R)                                                                   |                        |

| Review topics                                     | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23                | 2023/24                  | 2024/25                                                               | 2025/26                |
|---------------------------------------------------|-------------------|-------------------|----------------|------------------------|--------------------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                             | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b>         | <b>Limited</b>           | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Raising staff concerns/Safehaven/Speak out Safely |                   |                   |                | Reasonable             |                          | (R)                                                                   |                        |
| Recruitment/Establishment Control                 | Limited           |                   | Reasonable     | Limited<br>Substantial |                          | ✓                                                                     |                        |
| Engagement of Interim appointments                |                   | Limited           |                |                        | Assurance not applicable | Reasonable                                                            |                        |
| Sickness absence management                       |                   |                   |                |                        | (R)                      |                                                                       |                        |
| Staff Leavers                                     |                   |                   | Limited        |                        |                          |                                                                       |                        |
| Staff wellbeing                                   |                   |                   |                |                        |                          |                                                                       |                        |
| Statutory and mandatory training                  |                   |                   |                |                        |                          |                                                                       |                        |
| Temporary Staffing                                |                   |                   |                |                        |                          |                                                                       |                        |
| Upholding Professional Standards in Wales (UPSW)  |                   |                   | Reasonable     |                        |                          |                                                                       |                        |
| Violence & Aggression                             |                   | Limited           |                |                        |                          | (R)                                                                   |                        |
| Voluntary Early Release Scheme (VERS)             |                   |                   | Reasonable     | Reasonable             |                          |                                                                       |                        |
| Volunteers                                        |                   |                   |                |                        |                          |                                                                       |                        |
| Workforce Race Equality Standard (WRES)           |                   |                   |                |                        |                          |                                                                       | (R)                    |
| Waiting list initiative                           |                   |                   |                |                        |                          | (R)                                                                   |                        |



| Review topics                                            | 2019/ 20                 | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24                | 2024/25                                                               | 2025/26                |
|----------------------------------------------------------|--------------------------|-------------------|----------------|----------------|------------------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>                                    | <b>Reasonable</b>        | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b>         | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| <b>Project and programme risk</b>                        |                          |                   |                |                |                        |                                                                       |                        |
| Integrated Audit Plans - Major capital schemes assurance | Reasonable*5             | Reasonable        |                | Reasonable     | Reasonable<br>Deferred | ✓✓                                                                    | (R)                    |
| Discretionary funded schemes & equipment procurement     |                          |                   |                |                | (R)                    | (R)                                                                   | (R)                    |
| Capital Systems                                          |                          | Reasonable        | Substantial    |                |                        |                                                                       |                        |
| Vehicle, Equipment & IT Procurement                      | Assurance not applicable |                   |                |                |                        |                                                                       |                        |
| <b>Property</b>                                          |                          |                   |                |                |                        |                                                                       |                        |
| Corporate Legislative Compliance - Asbestos Management   |                          |                   | Reasonable     |                |                        | (R)                                                                   | (R)                    |
| Corporate Legislative Compliance - Fire Safety           | Reasonable               |                   |                |                |                        | Limited                                                               |                        |
| Corporate Legislative Compliance - Water Safety          |                          | Limited           |                |                | Limited                | (R)                                                                   |                        |
| Medical Gases                                            |                          |                   |                |                |                        |                                                                       |                        |
| Electricity Safety Regulations                           |                          |                   |                |                | (R)                    |                                                                       | (R)                    |
| Backlog Maintenance                                      |                          |                   |                |                |                        |                                                                       |                        |

| Review topics                     | 2019/ 20          | 2020/ 21          | 2021/ 22       | 2022/23        | 2023/24        | 2024/25                                                               | 2025/26                |
|-----------------------------------|-------------------|-------------------|----------------|----------------|----------------|-----------------------------------------------------------------------|------------------------|
| <b>ANNUAL OPINION</b>             | <b>Reasonable</b> | <b>Reasonable</b> | <b>Limited</b> | <b>Limited</b> | <b>Limited</b> | ✓ = April - September<br>✓✓ October - March<br>(R) = Risks identified | (R) = Risks identified |
| Minor works                       |                   |                   |                |                |                |                                                                       |                        |
| Maintenance and operations        |                   |                   |                |                |                |                                                                       |                        |
| Control of Contractors            |                   | Limited           |                |                |                |                                                                       |                        |
| Waste Management                  |                   |                   | Reasonable     |                |                | ✓✓                                                                    |                        |
| Residential Accommodation         |                   |                   |                |                |                | (R)                                                                   |                        |
| Property management               |                   |                   |                | Substantial    | (R)            |                                                                       |                        |
| Carbon Reduction Commitment       | Substantial       |                   |                |                |                |                                                                       |                        |
| Order/Decarbonisation             | Reasonable        | Substantial       |                | Advisory       | Limited        |                                                                       |                        |
| Environmental Sustainability      |                   |                   |                |                |                |                                                                       |                        |
| <b>Analysis of reviews</b>        |                   |                   |                |                |                |                                                                       |                        |
| Substantial                       | 2                 | 3                 | 1              | 3              | 2              | 0                                                                     |                        |
| Reasonable                        | 18                | 9                 | 16             | 10             | 8              | 2                                                                     |                        |
| Limited                           | 10                | 12                | 9              | 11             | 15             | 1                                                                     |                        |
| No assurance/Unsatisfactory       | 0                 | 0                 | 0              | 2              | 1              | 0                                                                     |                        |
| Assurance not applicable/Advisory | 3                 | 7                 | 8              | 4              | 4              | 0                                                                     |                        |
| <b>TOTAL number of reviews</b>    | <b>33</b>         | <b>31</b>         | <b>34</b>      | <b>30</b>      | <b>30</b>      | <b>3</b>                                                              |                        |



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## Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: October 2024

Document reference: 4538A2024

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.

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## About this document

- 1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 7 May 2024.
- 2 We also provide additional information on:
  - Other relevant examinations and studies published by the Audit General.
  - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

## Accounts audit update

4     **Exhibit 1** summarises the status of our current and planned accounts audit work.

### Exhibit 1 – Accounts audit work

| Area of work                         | Executive Lead                                           | Focus of the work                                                                       | Current status | Planned date for consideration |
|--------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------|--------------------------------|
| Audit of the Health Board's Accounts | Russell Caldicott, Interim Executive Director of Finance | Audit of Financial Statements Report including the Opinion on the Financial Statements. | Completed      | July 2024                      |



## Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

### Exhibit 2 – Performance audit work

| Area of work                                                         | Executive Lead                                        | Focus of the work                                                                                                                                                                                                                                                                                                         | Current status                                                                          | Planned date for consideration                              |
|----------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Structured Assessment – deep dive into financial efficiencies</b> | Executive Director of Finance and Corporate Resources | Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.                                                                                             | Completed                                                                               | November 2024                                               |
| <b>All Wales thematic work on Urgent and Emergency Care</b>          | Director of Therapies                                 | <p>This work examines different aspects of the urgent and emergency care system in three parts:</p> <ul style="list-style-type: none"> <li>• Part One: Flow out of hospital.</li> <li>• Part Two: accessing urgent and emergency care.</li> <li>• Part Three: national arrangements and leadership structures.</li> </ul> | <p>Part One: Completed</p> <p>Part Two: Report drafting</p> <p>Part Three: Planning</p> | <p>July 2024</p> <p>January 2025</p> <p>To be confirmed</p> |

| Area of work                        | Executive Lead                                     | Focus of the work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Current status | Planned date for consideration |
|-------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------|
| <b>Structured Assessment - core</b> | Director of Corporate Governance / Board Secretary | <p>This work will review the following core areas:</p> <ul style="list-style-type: none"> <li>• Board and committee effectiveness, cohesion, and transparency.</li> <li>• Corporate systems of assurance.</li> <li>• Corporate planning arrangements.</li> <li>• Corporate financial planning arrangements.</li> </ul> <p>This work will also seek to provide an update on the Health Board's progress in addressing audit recommendations made in previous structured assessment reports.</p>                                                                    | Fieldwork      | January 2025                   |
| <b>Planned Care</b>                 | Executive Medical Director                         | <p>This work will follow on from the national <a href="#"><u>report on tackling the planned care backlog</u></a>. Whilst the exact focus of this work is still to be determined, it is likely to consider:</p> <ul style="list-style-type: none"> <li>• The extent that health boards have achieved Welsh Government targets for recovering planned care services;</li> <li>• The efficacy of local plans and activity to recover waiting lists; and</li> <li>• Use of the additional Welsh Government financial allocations to improve waiting lists.</li> </ul> | Fieldwork      | March 2025                     |

| Area of work                                                                                                                         | Executive Lead                                        | Focus of the work                                                                                                                                                                                                                                                  | Current status | Planned date for consideration |
|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------|
| <b>Use of the strategic financial assistance provided by the Welsh Government for the 3.5-year period October 2020 to March 2024</b> | Executive Director of Finance and Corporate Resources | This audit will encompass a high-level examination of the Health Board's use of the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.                                 | Fieldwork      | March 2025                     |
| <b>Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation</b>    | Director of Digital Services                          | This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. | Scoping        | To be confirmed                |

| Area of work                                               | Executive Lead                | Focus of the work                                                                                                                                                    | Current status  | Planned date for consideration |
|------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------|
| <b>Follow on review of quality governance arrangements</b> | Executive Director of Nursing | This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process. | Not yet started | To be confirmed                |

## Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided.

### Exhibit 3 – Relevant examinations and studies published by the Auditor General

| Title                                                          | Publication Date |
|----------------------------------------------------------------|------------------|
| <a href="#">The National Fraud Initiative in Wales 2022-23</a> | October 2024     |
| <a href="#">Active Travel (and Data Tool)</a>                  | September 2024   |
| <a href="#">Affordable Housing</a>                             | September 2024   |
| <a href="#">NHS Wales Finance Data Tool</a>                    | August 2024      |
| <a href="#">Community Pharmacy Data Matching Pilot</a>         | May 2024.        |

## Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

### Exhibit 4 – Audit Wales corporate documents

| Title                                              | Publication Date |
|----------------------------------------------------|------------------|
| <a href="#">Annual Report and Accounts 2023/24</a> | August 2024      |





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

# Review of Cost Savings Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2023

Date issued: November 2024

Document reference: 4539A2024



This document has been prepared as part of work performed in accordance with statutory 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 and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at [infoofficer@audit.wales](mailto:infoofficer@audit.wales).

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

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# Detailed report

## Introduction

- 1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand, the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.
- 2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end audited position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total<sup>1</sup> deficit expected by Welsh Government.
- 3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

## Objectives and scope of our work

- 4 Given the challenges outlined above, the objective of our review has been to examine whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. The detailed audit criteria are set out in **Appendix 1**.
- 5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.
- 6 We undertook our work between December 2023 and March 2024. The methods we used to deliver our work are summarised in **Appendix 2**. Our work comments on the approach within the Health Board to identifying, delivering, and overseeing cost saving opportunities. It considers the impact these arrangements had on the 2023-24 year-end position and highlights where arrangements may need to be strengthened for 2024-25 and beyond.

<sup>1</sup> Revised deficit positions for 2023-24, known as 'control totals', were allocated to Health Boards by Welsh Government in November 2023 following the provision of additional funding to support their financial positions.

## Key findings

- 7 Overall, we found that **whilst the Health Board exceeded its savings target and almost met its control deficit target for 2023-24, it has a varied track record of delivering recurrent savings. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on rolling out and embedding its new cost savings arrangements across the organisation.**
- 8 The findings that support our overall conclusion are summarised below under the following headings:
- Identifying cost savings opportunities.
  - Delivering cost savings plans.
  - Monitoring and oversight of savings plans.

## Identifying cost savings opportunities

- 9 We considered whether the Health Board:
- has a clear understanding of the factors that are driving its costs;
  - routinely uses a range of data and intelligence to help identify cost savings opportunities; and
  - has an effective approach to selecting cost savings opportunities.
- 10 We found that **the Health Board has a good understanding of its cost drivers and has also developed a new approach for identifying transformational savings opportunities. However, opportunities remain to strengthen this approach further to ensure the Health Board can meet its financial challenges in both the short- and longer-term.**

## Understanding the drivers of cost

- 11 The Health Board has a good understanding of its cost drivers. Independent Members and Executive Directors routinely receive progress updates on these cost drivers as part of the Health Board's ongoing financial reporting and analysis. Reports highlight areas of high cost such as pay and non-pay costs (including nursing and medical agency costs), continuing health care, and medicines management. Whilst the Health Board has a good understanding of its cost drivers and made progress towards achieving its 2023-24 control total deficit of £20 million with a final year end position of £24 million deficit, these high-cost areas continue to be the key contributors to its challenging financial position and significant underlying deficit of £253 million.
- 12 The Health Board maintained a short-term focus on reducing its cost drivers in 2023-24 by introducing several specific financial control measures, including:
- a Vacancy Control Review process for particular grades and roles;

- a Recurrent Investment Group Assurance (RIGA) initiative to review previously committed investments and current year use of Performance and Transformation Budgets;
- additional non-pay checks and challenge process for over seventy areas of spend; and
- the introduction of additional in-year Divisional Expenditure Control Targets.

Whilst not all of these controls have generated budget releasing savings, they have resulted in the Health Board improving its financial position. However, whilst introducing these controls was necessary to prevent the Health Board's financial position from deteriorating further, some Directorates and Integrated Health Communities (IHCs) felt that the approach to their implementation was not as collaborative as it could have been.

- 13 For 2024-25, the Health Board has proposed a new approach to identifying and delivering savings based around the national Value and Sustainability Board<sup>2</sup> (VSB) workstreams. Some of these, particularly those around workforce and clinical variation, have the potential to deliver significant transformational efficiencies for the Health Board. However, sound budget management and ownership of financial targets and requirements at the operational level will also continue to be of central importance in identifying and addressing the factors that are driving costs within the organisation. During our review, concerns were raised from some operational areas about the accuracy of their base budgets. The Health Board, therefore, should seek to address this by demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered. (**Recommendation 1.1**)
- 14 The Health Board is still in the process of developing a clearer longer term Strategic Plan and Clinical Services Strategy. These are of fundamental importance in driving the service transformation that is needed in order to establish a service model that is clinically and financially sustainable, as highlighted in our 2023 Structured Assessment report and the Internal Audit report on savings<sup>3</sup> (noting also that there is still an outstanding recommendation from our 2022 Structured Assessment report relating to the development of a Clinical Services Plan).

<sup>2</sup> The national Value and Sustainability Board (VSB) was set up by Welsh Government and is chaired by NHS Executive to focus on specific themes to deliver possible pan Wales efficiencies. The workstreams include Continuing Health Care, Medicines Management, Workforce, Non-Pay, and Clinical Variation..

<sup>3</sup> Internal Audit completed a follow-up review of the 'Delivery of the Health Board's Savings'. Whilst the original report gave a 'No Assurance' rating, the follow-up has seen a very slight improvement to 'Limited Assurance'. The report was presented to the Audit Committee in March 2024.

## Using data and intelligence to identify cost savings opportunities

- 15 The Health Board's use of benchmarking data such as that from the VSB, VAULT<sup>4</sup>, and GIRFT<sup>5</sup> to support its cost efficiency and savings programme has been variable. This is mainly due to the historical resource and capacity challenges within the Finance Team to undertake this type of analysis work. In addition, the Health Board has confirmed that outputs from its GIRFT reviews do not necessarily always identify savings opportunities. Furthermore, when they highlight potential efficiency gains, they are not always progressed as they usually require a level of initial investment which the organisation is unable to provide due to its challenging financial position. The Health Board's new approach to savings identification through its VSB workstreams should provide a framework for making more systematic use of data and intelligence to support the identification of savings schemes. This approach will be supported by a new project team that will provide additional capacity to undertake this type of analysis work, which we discuss further in **paragraph 30**.
- 16 The Health Board has developed a proactive initiative to engage staff in identifying cost savings. The 'Small Change Big Difference' initiative enables engagement with staff on improvement and cost savings ideas. The Health Board has promoted this initiative through its management structures, team meetings, and regular Chief Executive staff briefings. At the time of our review, the initiative had generated sixty-one suggestions for further assessment. The Health Board intends to further embed this new approach during 2024-25. Notwithstanding the positive engagement of staff, our review identified limited evidence of the Health Board canvassing and using the views of service users and other stakeholders in the generation of savings ideas. As we discuss in **paragraph 17**, the Health Board intends to streamline and improve its savings guidance. This presents an opportunity to provide greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. (**Recommendation 3.1**)

## Selecting cost savings opportunities

- 17 The Health Board is continuing to improve its processes for savings selection as defined within its guidance and proformas on the submission of Savings Schemes and Savings Plans for 2024-25. The Health Board also intends to streamline and improve its savings guidance to ensure that all budget holders clearly understand

<sup>4</sup> The Value, Allocation, Utilisation and Learning Toolkit (VAULT) is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

<sup>5</sup> Getting it right first time (GIRFT) are programmes designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

its savings arrangements. When updating its guidance, the Health Board should take the opportunity to ensure that it also reflects its new savings approach based around its VSB workstreams. **(Recommendation 3.2)**

- 18 There is variability in the use of impact assessments for savings schemes, with some schemes not identifying the need for a quality impact assessment despite their potential clinical implications. We also heard concerns from some senior staff over the maturity of the Health Board's consideration of quality and patient safety in its savings arrangements. These arrangements will need to be strengthened through the VSB workstreams, particularly if the Health Board hopes to achieve greater levels of savings through more complex and challenging transformational change programmes. **(Recommendation 3.3)**
- 19 For 2024-25, the Health Board's financial plan reflects the challenges experienced in 2023-24 with a planned deficit position of £19.8 million and a savings requirement of £48 million. However, despite the scale of this challenge, the Health Board has been slow in selecting viable savings schemes for 2024-25. Independent Members have expressed concerns over the delays in both financial planning and developing viable savings schemes for 2024-25 and the potential impact this might have on the achievement and effective scrutiny of 2024-25 financial / savings plans. These concerns echo comments in our 2023 Structured Assessment report around the slow identification of savings schemes and converting schemes to 'green' within the Health Board's RAG classification of savings. **(Recommendation 2.1)**
- 20 The finance update to the Board in July 2024 indicates that the organisation continues to hold significant risks in respect of the savings it needs to deliver in order to achieve its 2024-25 control total deficit of £19.8 million. The Month 3 position showed a £21.5 million shortfall in the forecast savings position with £26.5 million of savings identified against a target of £48 million. Significant action over the remainder of the year is therefore needed in the identification and delivery of savings if the forecast year end position is to be achieved.

## Delivery of cost savings opportunities

- 21 We considered whether the Health Board has:
- a good track record of delivering savings plans and cost improvements
  - clear plans in place to deliver cost savings opportunities it identifies; and
  - the necessary skills and capacity to deliver its agreed cost savings opportunities.
- 22 We found that **whilst the Health Board's delivery of recurrent savings improved in 2023-24, savings performance was variable across its Integrated Health Communities and Directorates. As a result, it will need to identify and deliver significantly more recurrent savings at pace as well as strengthen financial competencies across the organisation if it is to achieve its challenging 2024-25 savings target.**

## Track record of delivery savings plans and cost improvements

- 23 Although the Health Board exceeded its savings target for 2023-24, it failed to do so in the previous five years (see **Exhibit 1**). Whilst there has been some challenge<sup>6</sup> over the accuracy of the 2023-24 savings target, its overall savings performance for 2023-24 is a significant improvement on prior years. However, this positive overall savings performance masks the significant variation in savings performance within the IHCs. For example, the Centre IHC achieved only 58% of its target savings, with less than 50% of these being recurrent in nature. Given that the IHCs account for most of the Health Board's budget, continued underperformance of savings in these areas will significantly undermine its ability to achieve its challenging savings target for 2024-25. (**Recommendation 2.2**) The Health Board also has a variable track record of delivering recurrent savings. Whilst it delivered significantly more recurrent savings in 2023-24 than in the prior three years, they only represented 63% of the total savings delivered. However, apart from 2020-21 and 2022-23, between 2018-19, and 2023-24 the percentage of recurrent savings delivered against the Health Board's overall savings target has exceeded 50%. (**Recommendation 2.3**)
- 24 The Health Board's track record of delivering savings in 2023-24 would have been worse than reported if it had reflected the additional 10% savings requirement of £13.4 million in its overall savings target and subsequent savings plans. The Welsh Government savings requirement of an additional 10% was set to deliver the Health Board's 2023-24 control total deficit of £20 million. Whilst the Health Board reported the need to deliver the additional 10% requirement in overall terms, its original savings target of £31 million was not updated to reflect this additional element and, therefore, was not part of its routine reporting on savings to the Board and the Performance, Finance, and Information Governance Committee. Whilst the Health Board exceeded its original 2023-24 savings target and almost achieved its 2023-24 control total, incorporating the additional savings target would have provided a more accurate picture of the overall savings required for 2023-24. This addition would have resulted in a savings target of £44 million and a reduction in the percentage of delivered recurrent savings from 63% to 50%. (**Recommendation 4**)

<sup>6</sup> Internal Audit's January 2024 follow-up report on the Delivery of Savings contains a management response highlighting some internal errors in the classification of stretch savings target with the correct savings target being £30.9 million. However, we note that the Health Board has continued to report its high-level performance against a savings target of £25.2 million, with a sub note that the additional £5 million were stretch targets.



## Exhibit 1 – Health Board’s savings track-record between 2018 and 2024

| Year    | Overall Savings Target £(M) | Actual overall savings delivered (£M) | Recurrent savings as a % of the higher of overall savings target or delivered | Delivered non-recurrent savings (£M) | Delivered recurrent savings (£M) |
|---------|-----------------------------|---------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|----------------------------------|
| 2018-19 | 45                          | 37                                    | 78%                                                                           | 2                                    | 35                               |
| 2019-20 | 45                          | 34                                    | 53%                                                                           | 10                                   | 24                               |
| 2020-21 | 45                          | 9.4                                   | 18%                                                                           | 1.2                                  | 8.2                              |
| 2021-22 | 17                          | 16.6                                  | 65%                                                                           | 5.5                                  | 11.1                             |
| 2022-23 | 35                          | 23                                    | 14%                                                                           | 18.1                                 | 4.9                              |
| 2023-24 | 31                          | 35                                    | 63%                                                                           | 14                                   | 22                               |

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports.

## Approach to delivery of savings plans

- 25 The Health Board has developed a targeted approach to delivering savings as part of wider efforts to strengthen its grip and control over its finances. As part of this approach, the Health Board allocated a savings target of 2.5% to all Directorates and IHCs in 2023-24 which has increased to 2.8% in 2024-25. As part of this, Directorates and IHCs are required to identify savings and produce an annual savings plan which outlines how they will achieve this target. However, our review highlighted concerns from Directorates and IHCs about the extent to which having a pan-Health Board savings target recognises their specific and unique context.  
**(Recommendation 1.2)**
- 26 The Health Board aligns its planning for cost savings with the development of its Integrated Medium-Term Plan (IMTP) and annual planning cycle. In our 2023

Structured Assessment report, we noted that the approach for financial planning for 2023-24 was affected by significant disruption at senior levels in the Finance Team and the high level of turnover of other senior staff. Notwithstanding this, the Health Board has made progress in developing its savings delivery plans. The master savings tracker captures individual savings schemes and includes key saving scheme data<sup>7</sup>.

- 27 The Health Board's new 2024-25 VSB workstreams were being finalised at the time of our review. Some initial observations indicate that the proposed governance structure for the individual workstreams should result in better engagement across the Health Board and increase the success of delivering savings schemes benefits. However, the outline framework could benefit from being clearer not only on the arrangements for considering the quality and patient safety impacts but also the extent to which savings schemes underpin the strategic direction of travel and consider the impact that they may have on other services as well as how Value Based Health Care (VBHC) initiatives would be integrated into the overall savings programme (see **Recommendation 3.3**).
- 28 The Health Board had drafted accountability letters for 2023-24, but these were not issued to IHCs and Directorates due to internal personnel changes within the Finance Team. Instead, the IHCs and Directorates were allocated individual control totals for 2023-24 in November 2023. The Health Board has confirmed that it was issuing new updated accountability letters for 2024-25. The accountability letters are an important component in the Health Board's overall approach to financial recovery and need to be used to provide clarity around roles, responsibilities, and financial targets. As such, they can help address some of the potential gaps in understanding / communications between the corporate Finance Team and the IHCs in relation to financial accountability and responsibility for initiating financial improvement plans. (**Recommendation 1.3**)

## Skills and capacity to deliver savings opportunities

- 29 The Health Board has taken some steps to develop financial competencies by issuing guidance through its Budget Holders Handbook and delivering training on procurement for budget holders. However, we were made aware of some financial competency gaps across areas of organisation which are impacting its ability to effectively manage its financial and savings planning. (**Recommendation 5.1**) Significant disruption at senior levels in the corporate Finance Team during 2023-24, and senior staff turnover, have also contributed to these challenges. The challenges around financial competencies also extend to Independent Members.
- 30 The Health Board indicated its intention to bolster its capacity for savings delivery in 2024-25 through its new centralised savings Value and Sustainability Project

<sup>7</sup> The master savings tracker data includes - savings classification, delivery milestones, and responsible officers. Saving scheme owners are required to identify other information, such as key risks and wider impacts during the initial saving planning stages.

Team. This team will comprise of staff from the Transformational Support Team, Corporate Finance Officer and Service Area Leads focussing on both central and locally identified savings opportunities. The Health Board proposes that the new team will link into national groups and other stakeholders on a regular basis to ensure that the opportunities to build upon national savings initiatives, data and learning are maximised within the Health Board. At the time of our work, this team was in the process of forming. However, once fully embedded, it should enable the Health Board to make greater use of data and intelligence to identify cost savings opportunities provide greater capacity to deliver its challenging 2024-25 savings target.

- 31 The Health Board's engagement with clinicians around savings is variable. The current Directorate Triumvirate Management structures within the IHCs and Directorates include senior clinical representatives and therefore provide a framework for clinical engagement around savings. However, the Health Board recognises that it needs to improve how clinicians are engaged in identifying and delivering financial efficiencies and savings. For 2024-25, the Health Board's new governance around its VSB workstreams will include clinical leads which should, when fully embedded, start to address this concern. However, it will be important that this positive clinical engagement approach also extends to the savings identified and delivered within the IHCs and Directorates where engagement with clinicians was considered to be variable. **(Recommendation 2.4)**

## Monitoring and oversight of cost savings delivery

- 32 We considered whether the Health Board:
- has an effective approach to monitoring and reporting the delivery of its cost savings plans;
  - identifies risks to the delivery of savings plans and actions to mitigate those risks; and
  - applies learning where cost savings plans previously haven't been achieved.
- 33 We found that **whilst the Health Board's arrangements for scrutinising, monitoring, tracking, and reporting on cost savings are improving, they have not resulted in improved financial performance across the organisation. As a result, it needs to better hold the Integrated Health Communities and Directorates to account for poor delivery of savings and strengthen its approach to sharing best practice and the lessons learnt from ineffective savings schemes.**

## Monitoring and reporting the delivery of savings plans

- 34 The Board has a clear understanding of the Health Board's financial challenges through its regular finance and savings reports. The Performance, Finance, and Information Governance Committee (PFIG) and Executive Finance and Information Delivery Group (EFIDG) also receive these detailed financial reports which

incorporate progress updates on savings. These reports are sufficiently detailed and granular to facilitate progress monitoring at the IHC and Directorate level. The Board has also taken part in several Board Development Sessions which have focused on finance, savings, and financial planning. Independent Members consider the quality of the financial information has improved over the last year and our observations at PFIG and Board meetings in February 2024 confirmed that there is a good level of challenge and debate around finance. However, as part of this review, we observed that some Independent Members ability to discharge their role would benefit from having a more detailed understanding of the Health Board's finances. **(Recommendation 5.2)**

- 35 In our 2023 Structured Assessment report, we commented that the Health Board is strengthening its oversight of savings plans through the Executive, the Executive Delivery Group for Performance and Finance, and routine review of major programmes and monthly review with service leads. The Finance Team has also undertaken several 'check and challenge' meetings with IHCs and Directorates to provide a focus on delivering financial targets, including savings. However, the Health Board has recognised it will need to continue to make improvements in key areas, such as clarifying the roles and accountability of senior management and continuing to improve its financial control environment in areas such as business case approval. Whilst these improvements will be crystalised in the Health Board's refreshed governance arrangements to support its new VSB workstreams, there is opportunity to strengthen these arrangements further by introducing a more structured escalation process for when IHCs and Directorates are not meeting their savings targets. **(Recommendation 2.5)**

## Identification of risks to savings plans delivery

- 36 The Health Board's Corporate Risk Register clearly identifies financial sustainability as a key corporate risk. The Executive Team, Risk Management Group, PFIG and Audit Committee regularly review this risk and have kept its status unchanged due to the Health Board's ongoing challenging financial position. Whilst the controls and assurances outlined for the Health Board's key financial sustainability risk appear to be reasonable, its financial position continues to remain challenging. Therefore, it will be important for the Board and its committees to continue to scrutinise the effectiveness of these controls to ensure that they remain fit for purpose.
- 37 The Health Board's savings guidance outlines the risk assessment of savings schemes, which follows the RAG savings risk classifications set out by Welsh Government. The master savings tracker reflects this RAG classification and forms the basis for savings classification in the savings tracker and internal and external reporting on savings. As we discussed in **paragraph 20**, as at Month 3 2024-25 the Health Board had identified £26.5 million of savings, which were classified as 'green'. This equates to 55% of the Health Board's overall savings target for 2024-25. The Health Board, therefore, continues to carry a significant risk to achieving its

overall savings target for 2024-25 unless it converts the remaining ‘amber’ and ‘red’ schemes to recurrent ‘green’ schemes at pace.

## Applying learning

- 38 The Health Board does not have a well-developed approach to learning lessons from underperforming savings schemes. There were some limited examples of informal sharing of ideas and learning between IHCs and Directorates and some parts of the Health Board have been working with the NHSE F&DT<sup>8</sup> to access learning from across Wales to support the development of savings opportunities. However, in overall terms the Health Board needs to embed a more systematic approach to learning lessons from others, and to understand why saving schemes it has identified have failed or underperformed. The Health Board has told us that its recently established VSB workstreams should, when embedded, provide greater opportunity to adapt its approach to savings based on learning.  
(Recommendation 6)

## Recommendations

- 39 **Exhibit 2** details the recommendations arising from this audit.

### Recommendations

- R1 The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through:
- R1.1 Demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered.  
(Paragraph 13)
  - R1.2 Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target. (Paragraph 25)
  - R1.3 Ensuring that accountability letters are issued in a timely manner and clearly set out the roles, responsibilities, and accountabilities of the Directorates, Integrated Health Communities, and the corporate centre.  
(Paragraph 28)

<sup>8</sup> National Health Service Executive Wales – Financial Delivery Team (NHSE FDT)

## Recommendations

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- R2 The Health Board should strengthen its approach to the identification and delivery of savings by:
- R2.1 Identifying viable savings schemes to meet the Health Board's overall savings target earlier in the financial planning cycle. **(Paragraph 19)**
  - R2.2 Taking earlier remedial action to bring under-performing saving schemes back on track. **(Paragraph 23)**
  - R2.3 Maintaining a focus on the identification of saving schemes that deliver recurrent savings. **(Paragraph 23)**
  - R2.4 Securing greater engagement from clinicians in the development and delivery of savings schemes. **(Paragraph 31)**
  - R2.5 Introducing a more formalised escalation process where Directorates and IHCs are not delivering against their savings targets. **(Paragraph 35)**
- 
- R3 When updating its savings guidance, the Health Board should ensure:
- R3.1 That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. **(Paragraph 16)**
  - R3.2 That the guidance reflects the new savings approach based around its Value and Sustainability Board framework. **(Paragraph 17)**
  - R3.3 That the guidance clearly articulates the arrangements for assessing the impact of savings schemes on quality and patient safety, how they support the Health Board's strategic priorities, and impact on other services, as well as the integration with other initiatives (such as Value Based Health Care). **(Paragraphs 18 & 27)**
- 
- R4 The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. **(Paragraph 24)**
- 
- R5.1 The Health Board should ensure that it has a clear programme in place to address the financial capability gaps across the organisation to ensure operational managers have the necessary skills to support financial planning and savings delivery arrangements. **(Paragraph 28)**
- R5.2 The Health Board should put arrangements in place to support Independent Members to gain a better understanding of the organisation's finances. **(Paragraph 34)**

## Recommendations

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- R6 The Health Board should adopt a more systematic approach to the identification and sharing of learning on the delivery of savings schemes. This should include lessons learnt from Health Board savings schemes which have failed or underperformed and the sharing of good practice from the approach to savings schemes in other organisations. **(Paragraph 38)**

# Appendix 1

## Audit criteria

**Exhibit 3** below sets out the detailed audit criteria for this review.

### Identifying cost savings opportunities

| Area                              | Audit Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Understanding the drivers of cost | <ul style="list-style-type: none"><li>• The organisation's opening balance sheet is true and fair.</li><li>• The organisation has effective arrangements in place for identifying and analysing the full range of pay and non-pay factors driving its costs in the short, medium, and long-term.</li><li>• The organisation has a good understanding of the scale of cost savings required to achieve financial sustainability in the short, medium, and long-term and has set realistic and achievable targets accordingly.</li><li>• The Board is appropriately involved in overseeing, scrutinising, and challenging the organisation's financial analysis and cost savings targets.</li></ul> |



**Using data and intelligence to identify cost savings opportunities**

- The organisation routinely accesses and uses benchmarking information from a range of sources (e.g. NHS Benchmarking, CHKS, Medicines Management KPIs)
- The organisation routinely accesses and uses efficiencies data and information from a range of sources (e.g. NHS Wales Efficiency Framework / VAULT, GIRFT reviews, local Value-based Healthcare reviews / opportunities)
- The organisation has clear processes in place to canvas, capture, and assess ideas and suggestions on cost savings opportunities from staff, service-users, and other stakeholders on a regular basis.
- The organisation has clear processes in place for responding to centrally identified cost savings opportunities from the NHS Wales Value and Sustainability Board.

**Selecting cost savings opportunities**

- The organisation has a clear and iterative process in place to appraise all potential cost savings opportunities for achievability and for impact on delivering the organisation's strategic aims, well-being objectives, population health, the quality and safety of services, and ability to meet performance targets / service specifications in the short, medium, and long-term.
- The organisation has a clear and iterative process in place for scrutinising, agreeing, and approving cost savings opportunities, which also involves the Board and its relevant committee(s).
- The organisation's agreed cost savings opportunities:

- are realistic, achievable, and focus on maximising value to the health of the population being served;
  - cover the breadth of the organisation's clinical, administrative, and technical functions;
  - balance one-off non recurrent savings with more sustainable saving opportunities;
  - incorporate productivity savings, but recognise these will not lead to a reduction in monetary terms; and
  - focus on medium- to longer-term transformation, as well as short-term and incremental opportunities.
- have been scaled and targeted appropriately across all parts of the organisation (rather than a standard percentage applied across all parts.)

## Delivery of cost savings opportunities

| Area                                         | Audit Criteria                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Approach to delivery of savings plans</b> | <ul style="list-style-type: none"> <li>• The organisation has plans in place for delivering cost savings opportunities which clearly set out: <ul style="list-style-type: none"> <li>- the financial savings that will be delivered and how they will be measured;</li> <li>- the anticipated impact on strategy, quality, and / or performance;</li> </ul> </li> </ul> |

- the key risks, controls, and mitigating actions;
- any interdependency with other cost savings plans;
- any dependency on other organisational work streams and strategies;
- key delivery milestones; and
- which senior officer is responsible and accountable for delivery.
- The organisation has effective arrangements in place for managing cross-cutting cost savings plans.
- The organisation has appropriate arrangements in place to communicate its cost savings plans to staff, service-users, and other stakeholders.

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**Skills and capacity to deliver savings opportunities**

- Roles and responsibilities in relation to delivering cost savings plans at all levels of the organisation are clearly documented and understood.
- The organisation has assessed the skills / capability and capacity required to deliver its cost savings plans at both a corporate and operational level and has put appropriate arrangements in place to address any shortfalls and gaps (including the appropriate use of external capacity / expertise.)
- The organisation has appropriate corporate structures and resources in place (such as a Programme Management Office) to:
  - keep delivery on track,

- provide challenge when needed,
- support corporate and operational staff to manage delivery risks, and
- provide an agile and timely response to under-performance / under-delivery.

**Track record of delivery savings plans and cost improvements**

- Cost savings plans in recent years have been largely achieved.
- There is evidence of learning being applied where cost savings plans previously haven't been achieved.

## Monitoring and oversight of cost savings delivery

| Area                                            | Audit Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monitoring the delivery of savings plans</b> | <ul style="list-style-type: none"> <li>• The organisation has clear arrangements in place for monitoring delivery which reflect the timescales and risks associated with delivering individual plans and the overall cost savings target.</li> <li>• The organisation has selected appropriate key KPIs and has put effective controls in place to ensure the quality of underlying data are reliable for effective monitoring and reporting.</li> <li>• The organisation's approach to monitoring and tracking delivery of its cost savings plan is appropriately aligned to its broader financial management arrangements (e.g., Standing Financial Instructions, Schemes of Reservation and Delegation, budget allocations.)</li> </ul> |

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                          | <ul style="list-style-type: none"> <li>• The organisation produces tailored reports that meet the differing needs of users in the governance chain.</li> <li>• The organisation ensures that delivery of cost savings is accurately reflected in finance reports presented to the Board and / or its relevant committee(s).</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Identification of risks to savings plans delivery</b> | <ul style="list-style-type: none"> <li>• The organisation has identified and documented the key risks to delivery in the appropriate risk registers (operational, corporate, and Board Assurance Framework.)</li> <li>• The organisation is actively managing / mitigating the risks at the appropriate level.</li> <li>• The organisation has appropriate arrangements in place to identify and escalate cost savings plans that are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.</li> <li>• The organisation takes appropriate action in a timely manner where cost savings plans are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.</li> </ul> |
| <b>Applying learning</b>                                 | <ul style="list-style-type: none"> <li>• The organisation seeks assurance on its arrangements by using internal audit, or a similar independent and objective reviewer.</li> <li>• The organisation appropriately evaluates its approach to achieving cost savings.</li> <li>• The organisation actively uses its own evaluation(s) and assurances provided by internal audit to identify lessons learned and to change / improve its arrangements.</li> </ul>                                                                                                                                                                                                                                                                                                        |

- Lessons learned and changes / improvements are reported to the Board and / or its relevant committee(s) to enable an agile response in-year.
- The organisation has appropriate arrangements in place to fully transfer and / or integrate changes arising from its cost savings plans to its business-as-usual operations and activities.

# Appendix 2

## Audit methods

**Exhibit 4** below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

| Element of audit approach | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Self-assessment           | The Health Board completed a self-assessment structured around the audit criteria.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Documents                 | We reviewed a range of documents, many of which were provided in support of the self-assessment, including: <ul style="list-style-type: none"><li>• Board and Committees agenda's, papers, and minutes</li><li>• Key organisational strategies and plans</li><li>• Savings benchmarking data</li><li>• Key risk management documents, including the Board Assurance Framework and Corporate Risk Register</li><li>• Key reports and plans relation to organisational finances and savings</li><li>• Reports prepared by the Internal Audit service.</li></ul> |

| Element of audit approach | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interviews                | <p>We interviewed the following senior officers and Independent Members:</p> <ul style="list-style-type: none"> <li>• Chief Executive Officer</li> <li>• Interim Executive Director of Finance</li> <li>• Executive Medical Director</li> <li>• Director of East Integrated Health Community</li> <li>• Chair of Performance Finance and Information Governance Committee</li> <li>• Director of Centre Integrated Health Community</li> <li>• Director of West Integrated Health Community</li> <li>• Director of Midwifery and Women's Services</li> <li>• Director of Mental Health and Learning Disabilities</li> <li>• Finance Director Commissioning and Financial Planning</li> <li>• Interim Finance Director: Operational Finance</li> </ul> |
| Observations              | <p>We observed Board meetings as well as meetings of the following committee:</p> <ul style="list-style-type: none"> <li>• Performance Finance and Information Governance Committee (PFIGC)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |





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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.

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|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Teitl adroddiad:</b>      | <b>Local Counter Fraud Service – Progress Report</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Report title:</b>         | <b>1 July 2024 - 30 September 2024 (Quarter 2)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Adrodd i:</b>             | Audit Committee (Public Session)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Report to:</b>            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Dyddiad y Cyfarfod:</b>   | Tuesday, 05 November 2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Date of Meeting:</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Crynodeb Gweithredol:</b> | The Local Counter Fraud Service – Progress Report updates the Health Board, via the Audit Committee, on the progress of Local Counter Fraud Service operational work which has been undertaken during the second three-month period ended 30 September 2024.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Executive Summary:</b>    | <p>Key points:</p> <ul style="list-style-type: none"> <li>• The vacant Head of Local Counter Fraud Services post was advertised and interviews took place in October. The successful candidate commences in post on the 1st December 2024.</li> <li>• Summary of the key activities: <ul style="list-style-type: none"> <li><u>Proactive</u> <ul style="list-style-type: none"> <li>○ Reviewed and fraud proofed various policies and procedures, to ensure that they are and remain fit for purpose at the Health Board and ensure public funds remain safe from economic crime.</li> <li>○ 62 staff members have received a Fraud Awareness Presentation (117 YTD).</li> <li>○ Media reports or news articles / fraud deterrence activities published in Q1 2024/25 relating to successful cases or Counter Fraud activities is 18 (35 YTD).</li> <li>○ Provided guidance to the Health Board's Controlled Drugs and Local Intelligence Network Committee (CD LIN).</li> <li>○ Q2 Counter Fraud Newsletter (Issue no. 34 - Theme - Pharmaceutical Contractor fraud - Deterrence Article) circulated electronically to Health Board staff and all primary care contractors and to North Wales Police.</li> <li>○ Promotion of the mandatory programme of Fraud Awareness training for staff. 2,753 staff completed the training in Q2 (6,593 YTD) (BCU leading NHS Wales in stats)</li> <li>○ Circulated National Alerts, Guidance and Circulars</li> <li>○ Worked closely with NHS Wales Shared Services Partnership (NWSSP) on Post Payment Verification of General medical Services (GMS) and General Ophthalmic Services (GOS)</li> <li>○ Provided advice and assistance to line managers, workforce colleagues and external Primary Care Contractors.</li> <li>○ Undertaken 3 Fraud Risk Assessments (9 YTD).</li> </ul> </li> </ul> </li> </ul> <p><u>Reactive</u> (cases) – see Private Session report for further details:</p> |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <table border="1"> <tr> <th>Quarter</th> <th>New referrals received</th> <th>Investigations closed</th> <th>Cases open at quarter end</th> </tr> <tr> <td>1 24/25</td> <td>8</td> <td>6</td> <td>25</td> </tr> <tr> <td>2 24/25</td> <td>12</td> <td>5</td> <td>32</td> </tr> </table> |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             | Quarter                  | New referrals received | Investigations closed          | Cases open at quarter end | 1 24/25 | 8 | 6 | 25 | 2 24/25 | 12 | 5 | 32 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------|--------------------------------|---------------------------|---------|---|---|----|---------|----|---|----|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Quarter                                                                                                                                                                                                                                                                                | New referrals received                                                                                                                                                                                                                                        | Investigations closed                                                                                                                                                                                                                         | Cases open at quarter end                                                                                                                                                   |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1 24/25                                                                                                                                                                                                                                                                                | 8                                                                                                                                                                                                                                                             | 6                                                                                                                                                                                                                                             | 25                                                                                                                                                                          |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2 24/25                                                                                                                                                                                                                                                                                | 12                                                                                                                                                                                                                                                            | 5                                                                                                                                                                                                                                             | 32                                                                                                                                                                          |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <p>The Counter Fraud Wales Team, who investigate the fraud cases that are &gt;£15k or involve financial investigation powers, have two open cases for the Heath Board at the end of Quarter 2. These relate to potential offences of 1) Manger Fraud by Abuse of Position and 2) Senior Managers/Contractors Misconduct in Public Office/Fraud by Abuse of Position.</p>                                                                            |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <table border="1"> <tr> <th>No of open cases as at 01/06/2024</th> <th>No of referrals received</th> <th>No of cases closed</th> <th>No of open cases at 30/09/2024</th> </tr> <tr> <td>3</td> <td>0</td> <td>1</td> <td>2</td> </tr> </table>                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               | No of open cases as at 01/06/2024                                                                                                                                           | No of referrals received | No of cases closed     | No of open cases at 30/09/2024 | 3                         | 0       | 1 | 2 |    |         |    |   |    |
| No of open cases as at 01/06/2024                                                                                                                                                                                                                                                                                                                                                                                                                   | No of referrals received                                                                                                                                                                                                                                                               | No of cases closed                                                                                                                                                                                                                                            | No of open cases at 30/09/2024                                                                                                                                                                                                                |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                                                                                                                                                                                                                                                                      | 1                                                                                                                                                                                                                                                             | 2                                                                                                                                                                                                                                             |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Argymhellion:</b><br><br><b>Recommendations:</b>                                                                                                                                                                                                                                                                                                                                                                                                 | <p>The Committee is asked to:</p> <p>Note the contents of this update report</p>                                                                                                                                                                                                       |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Arweinydd Gweithredol:</b><br><br><b>Executive Lead:</b>                                                                                                                                                                                                                                                                                                                                                                                         | <p>Mr Russell Caldicott – Interim Executive Director of Finance</p>                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Awdur yr Adroddiad:</b><br><br><b>Report Author:</b>                                                                                                                                                                                                                                                                                                                                                                                             | <p>Andrea J Hughes – Interim Finance Director - Operational</p>                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Pwrpas yr adroddiad:</b><br><b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                            | <b>I'w Nodi</b><br><i>For Noting</i><br><input checked="" type="checkbox"/>                                                                                                                                                                                                            | <b>I Benderfynu arno</b><br><i>For Decision</i><br><input type="checkbox"/>                                                                                                                                                                                   | <b>Am sicrwydd</b><br><i>For Assurance</i><br><input type="checkbox"/>                                                                                                                                                                        |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Lefel sicrwydd:</b><br><br><b>Assurance level:</b>                                                                                                                                                                                                                                                                                                                                                                                               | <b>Arwyddocaol</b><br><i>Significant</i><br><input checked="" type="checkbox"/><br><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>                | <b>Derbyniol</b><br><i>Acceptable</i><br><input type="checkbox"/><br><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Rhannol</b><br><i>Partial</i><br><input type="checkbox"/><br><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | <b>Dim Sicrwydd</b><br><i>No Assurance</i><br><input type="checkbox"/><br><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br><i>No confidence / evidence in delivery</i> |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b>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:</b></p> |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |
| <b>Cyswllt ag Amcan/Amcanion Strategol:</b><br><br><b>Link to Strategic Objective(s):</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                        | <p>The Local Counter Fraud Service Workplan for 2024/25 was approved by the Audit Committee on 7 May 2024</p>                                                                                                                                                 |                                                                                                                                                                                                                                               |                                                                                                                                                                             |                          |                        |                                |                           |         |   |   |    |         |    |   |    |

|                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>                                                                                                                                                                                             | <p>The progress against the Local Counter Fraud Service Workplan for 2024/25 will be reported to the Audit Committee and also to Welsh Government.</p>                                                                                                                                                                                                                             |
| <p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b></p>                                                                                                              | <p>Do/Naddo   Y/N   No</p> <p>Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption.</p> <p><a href="#"><u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u></a></p> <p><a href="#"><u>WP7 Procedure for Equality Impact Assessments</u></a></p> |
| <p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>                                                                                                               | <p>Do/Naddo   Y/N   No</p> <p>Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.</p> <p><a href="#"><u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u></a></p> <p><a href="#"><u>WP68 Procedure for Socio-economic Impact Assessment.</u></a></p>                      |
| <p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p> | <p>This paper is intended to draw to the Audit Committee's attention, the progress of work which has been undertaken in accordance with the Welsh Government Directions to protect NHS financial resources from Fraud, Bribery and Corruption.</p>                                                                                                                                 |
| <p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>                                                                                                                           | <p>The expenditure required to undertake the programme of Local Counter Fraud Service work for the Health Board, which was previously approved by the Audit Committee, and is budgeted.</p>                                                                                                                                                                                        |
| <p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>                                                                                                                           | <p>There are no Workforce policy implications contained in this report. Any disciplinary staffing issues will be dealt with following Health Board Workforce policies.</p>                                                                                                                                                                                                         |
| <p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>                                                                                                                                           | <p>The paper has been subject to Executive review and sign off.</p>                                                                                                                                                                                                                                                                                                                |

|                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>Cysylltiadau â risgiau BAF:</b><br/>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b><br/>(or links to the Corporate Risk Register)</p>                                                                                                                                                                               | <p>Risk of significant financial loss due to Salary Overpayments (Risk Register 2601)</p> <p>Potential Loss of income to Overseas Visitor Patients (Risk Register 3058)</p> <p>General Medical Services - Capitation / Patient Registration Fees (Risk Register 3061)</p> <p>Pharmaceutical Fraud (Risk Register 3064)</p> <p>Private Patients (Risk Register 3060)</p> <p>Cyber Enabled Salary Diversion (Risk Register 4165)</p> <p>Continence Services (Risk Register 4170)</p> <p>Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171)</p> <p>Hospital Mortality Services (Risk Register 4172)</p> |
| <p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>Camau Nesaf:</b><br/><b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b><br/><b>Implementation of recommendations</b></p> <p>The Committee is required to note the contents of this Local Counter Fraud Service – Progress Report. This information forms part of all Wales Counter Fraud Wales Reports which are shared with Welsh Government.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <p>Appendix A: NHS Wales Counter Fraud Resources 2024/25</p>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## Appendix A: NHS Wales Counter Fraud Resources 2024/25

| NHS WALES COUNTER FRAUD RESOURCE 2024/25      |                 |                          |                          |                 |                 |                 |                        |                                   |                              |
|-----------------------------------------------|-----------------|--------------------------|--------------------------|-----------------|-----------------|-----------------|------------------------|-----------------------------------|------------------------------|
| Health Body                                   | LCFS Annual WTE | Admin Support Annual WTE | Annual Planned LCFS Days | Q1 LCFS Days    | YTD LCFS Days   | Salary Costs Q1 | Annual Staffing budget | Staff Headcount (at 31.03.24) *** | LCFS wte per 1,000 NHS staff |
| Aneurin Bevan UHB (ABUHB)                     | 3.00            | 0                        | 630                      | 125             | 125             | £51,816         | £207,264               | 15,410                            | 0.19                         |
| Betsi Cadwaladr UHB (BCUHB)                   | 2.91            | 0.5                      | 590                      | 159             | 159             | £45,694         | £193,529               | 21,283                            | 0.14                         |
| Cardiff & Vale UHB (CVUHB) *                  | 2.18            | 0                        | 480                      | 128             | 128             | £36,008         | £144,032               | 17,247                            | 0.13                         |
| Cwm Taf Morgannwg UHB CTMUHB) **              | 2.60            | 0.2                      | 606                      | 152             | 152             | £37,818         | £151,272               | 12,991                            | 0.20                         |
| Digital Health & Care Wales (DCHW) *          | 0.39            | 0                        | 85                       | 20              | 20              | £6,377          | £25,506                | 1,244                             | 0.31                         |
| Health Education & Improvement Wales (HEIW) * | 0.39            | 0                        | 85                       | 20              | 20              | £6,377          | £25,506                | 542                               | 0.72                         |
| Hywel Dda UHB (H DUHB)                        | 2.00            | 0                        | 420                      | 105             | 105             | £23,529         | £94,116                | 12,179                            | 0.16                         |
| NHS Wales Shared Services Partnership (NWSSP) | 1.00            | 0                        | 210                      | 48.75           | 48.75           | £12,522         | £50,088                | 5,766                             | 0.17                         |
| Powys THB (PTHB) **                           | 1.20            | 0.3                      | 308                      | 77              | 77              | £19,896         | £79,582                | 2,582                             | 0.46                         |
| Public Health Wales (PHW) *                   | 0.45            | 0                        | 100                      | 22              | 22              | £7,502          | £30,007                | 2,425                             | 0.19                         |
| Swansea Bay UHB (SBUHB) **                    | 3.20            | 0.4                      | 704                      | 176             | 176             | £44,371         | £177,484               | 14,322                            | 0.22                         |
| Velindre NHS Trust (VUNHST) *                 | 0.45            | 0                        | 100                      | 22              | 22              | £7,502          | £30,007                | 1,781                             | 0.25                         |
| Welsh Ambulance Service Trust (WAST)          | 2.00            | 0                        | 420                      | 105             | 105             | £29,500         | £118,000               | 4,333                             | 0.46                         |
| <b>TOTAL</b>                                  | <b>21.77</b>    | <b>1.4</b>               | <b>4,738</b>             | <b>1,159.75</b> | <b>1,159.75</b> | <b>£328,912</b> | <b>£1,326,393</b>      | <b>112,105</b>                    | <b>Average is 0.25</b>       |
| NHS Counter Fraud Service Wales (CFS Wales)   | 6               | 1                        | 1,314                    | 274             | 274             | £111,097        | £444,389               |                                   |                              |
| <b>ALL WALES TOTAL</b>                        | <b>27.77</b>    | <b>2.4</b>               | <b>6,052</b>             | <b>1433.75</b>  | <b>1433.75</b>  | <b>£440,009</b> | <b>£1,770,782</b>      |                                   |                              |

\* C&V UHB LCFS Team provide an LCFS service to Velindre UNHST, HEIW, DHCW and PHW via an annual SLA. The LCFS service they provided to NWSSP ended on 30.6.23.

\*\* Swansea Bay UHB LCFS Team provide LCFS services to CTMUHB and PTHB via an annual SLA.

\*\*\* Staff Headcount data is obtained from Welsh Government Stats Wales website.

|                                                                                                                                                                                                             |                                                                            |                                                     |  |                                                  |  |                                                |          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------|--|--------------------------------------------------|--|------------------------------------------------|----------|
| <b>Cyfarfod a dyddiad:</b><br><b>Meeting and date:</b>                                                                                                                                                      | Audit Committee                                                            |                                                     |  |                                                  |  |                                                |          |
| <b>Cyhoeddus neu Breifat:</b><br><b>Public or Private:</b>                                                                                                                                                  | Public                                                                     |                                                     |  |                                                  |  |                                                |          |
| <b>Teitl yr Adroddiad</b><br><b>Report Title:</b>                                                                                                                                                           | Summary of business considered in private session to be reported in public |                                                     |  |                                                  |  |                                                |          |
| <b>Cyfarwyddwr Cyfrifol:</b><br><b>Responsible Director:</b>                                                                                                                                                | Pam Wenger, Director of Corporate Governance                               |                                                     |  |                                                  |  |                                                |          |
| <b>Awdur yr Adroddiad</b><br><b>Report Author:</b>                                                                                                                                                          | Philippa Peake-Jones, Head of Corporate Affairs                            |                                                     |  |                                                  |  |                                                |          |
| <b>Craffu blaenorol:</b><br><b>Prior Scrutiny:</b>                                                                                                                                                          | None                                                                       |                                                     |  |                                                  |  |                                                |          |
| <b>Atodiadau</b><br><b>Appendices:</b>                                                                                                                                                                      | None                                                                       |                                                     |  |                                                  |  |                                                |          |
| <b>Y/N to indicate whether the Equality/SED duty is applicable</b>                                                                                                                                          |                                                                            |                                                     |  |                                                  |  |                                                | <b>N</b> |
| <b>Argymhelliad / Recommendation:</b>                                                                                                                                                                       |                                                                            |                                                     |  |                                                  |  |                                                |          |
| The Committee is asked to note the report.                                                                                                                                                                  |                                                                            |                                                     |  |                                                  |  |                                                |          |
| <b>Ar gyfer penderfyniad /cymeradwyaeth</b><br><b>For Decision/ Approval</b>                                                                                                                                |                                                                            | <b>Ar gyfer Trafodaeth</b><br><b>For Discussion</b> |  | <b>Ar gyfer sicrwydd</b><br><b>For Assurance</b> |  | <b>Er gwybodaeth</b><br><b>For Information</b> | ✓        |
| <b>Sefyllfa / Situation:</b>                                                                                                                                                                                |                                                                            |                                                     |  |                                                  |  |                                                |          |
| To report in public session on matters previously considered in private session.                                                                                                                            |                                                                            |                                                     |  |                                                  |  |                                                |          |
| <b>Cefndir / Background:</b>                                                                                                                                                                                |                                                                            |                                                     |  |                                                  |  |                                                |          |
| Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings. |                                                                            |                                                     |  |                                                  |  |                                                |          |
| <b>Asesiad / Assessment</b>                                                                                                                                                                                 |                                                                            |                                                     |  |                                                  |  |                                                |          |
| The Committee considered the following matters in private session:                                                                                                                                          |                                                                            |                                                     |  |                                                  |  |                                                |          |
| <b>12 September 2024</b>                                                                                                                                                                                    |                                                                            |                                                     |  |                                                  |  |                                                |          |
| <ul style="list-style-type: none"> <li>Freedom of Information Request</li> <li>Counter Fraud Progress Report</li> </ul>                                                                                     |                                                                            |                                                     |  |                                                  |  |                                                |          |

## Audit Committee – Non-Routine Committee Business Workplan

(1 April 2024 – 31 March 2025)

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

| Date of Request | Origin of Request                                        | Requestor                    | Item Summary / Title                                                                                                                                   | Nature of Request                                                                                                                                                                                                                                         | Lead Officer            | Executive Lead    | Intended Meeting Date | Status                                                       |
|-----------------|----------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------|-----------------------|--------------------------------------------------------------|
| 24.08.24        | Email from Andrea Hughes on 24.08.24                     | Andrea Hughes                | Counter Fraud Policy – was due to Sept meeting but not ready, also not ready for Nov meeting, needs to go to consultation (see email from AH 24.10.24) | Counter Fraud Policy to go to Committee                                                                                                                                                                                                                   | Andrea Hughes           | Russell Caldicott | 16.01.25              | Policy to go to consultation so will go to Jan mtg           |
| 12.09.24        | Action from Audit Committee 12.09.24                     | Audit Committee              | Audit Wales Community Pharmacy Data Matching Pilot                                                                                                     | Lois Lloyd to provide an update to the Committee                                                                                                                                                                                                          | Lois Lloyd              | Pam Wenger        | 16.01.25              |                                                              |
| 16.09.24        | Action AC24.94.9 from Audit Committee                    | Audit Committee              | Effective Governance – (IHC) Central - Final Internal Audit Report                                                                                     | Update on the impact of the actions being taken to reduce the number of outstanding complaint responses (see email sent to Di Platt 01.10.24) PW suggested adding to agenda under an item – Update on Internal Audit Actions (see email from PW 08.10.24) | Gareth Evans / Di Platt | Gareth Evans      | 16.01.25              |                                                              |
| 24.10.24        | Action AC24/124.2 from Audit Committee                   | Audit Committee / Pam Wenger | Health Board Policies                                                                                                                                  | A summary as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.                                                                                                                    | Glesni Driver           | Pam Wenger        | 16.01.25              |                                                              |
| 24.10.24        | Action AC24/124.3 from Audit Committee                   | Audit Committee / Pam Wenger | Health Board Policies                                                                                                                                  | Establish a long term review of the process for reviewing policies and procedures.                                                                                                                                                                        | Glesni Driver           | Pam Wenger        | 16.01.25              |                                                              |
| 02.09.24        | Action from Audit Committee 18.07.24<br>Action AC24.95.7 | Audit Committee              | Session with Board Members to discuss the role and operations of Shared Services                                                                       | This has been included on the Audit Committee Development Plan                                                                                                                                                                                            | Pam Wenger              | Pam Wenger        | 05.11.24              | <b>CLOSED</b><br>This is included on the AC Development Plan |
| 02.09.24        | Action from private Audit Committee 21.05.24             | Audit Committee              | Development session with Board Members on Counter Fraud                                                                                                | This has been included on the Audit Committee Development Plan                                                                                                                                                                                            | Pam Wenger              | Pam Wenger        | 05.11.24              | <b>CLOSED</b><br>This is included on the AC Development Plan |