Bundle Audit Committee 15 May 2023

1.1	AC23.17 OPENING BUSINESS - OPEN SESSION
1.2	AC23.18 Apologies for Absence
1.3	AC23.19 Declarations of Interest
1.4	AC23.20 Minutes of Previous Meeting
	To confirm the Minutes of the last meeting of the Committee held on 13 January 2023 as a correct record and to discuss any matter arising; and *To review the Summary Action Log* AC23.20 Draft minutes.docx
1.5	AC23.21 Action Point Register AC23.21 action point register.xlsx
2.5.A	AC23.22 Internal Audit Progress Report AC23.21a - IA progress report Cover Sheet.docx
2.5.B	AC23.23 Internal Audit Plan AC23.22b - IA audit plan 202324.docx
2.5.C	AC23.24 IA final report: Delivery of Health Board Savings AC23.24 - Health Board Savings.pdf
2.5.D	AC23.25 IA final report: Business Case outcomes AC23.25 - Business case outcomes.pdf
2.5.E	AC23.26 Internal Audit Recommendations AC23.26 recommendations.docx
2.6.A	AC23.27 Risk Management AC23.27 Risk Report.docx
2.6.B	AC23.28 Board Assurance Framework -AC23.28 Board Assurance Framework.xlsx
9.9	AC23.39 Any other Business
10.10	AC23.40 Date of next meeting

AUDIT COMMITTEE PUBLIC MEETING
Draft Minutes of the Meeting Held on 13.1.23
Via Microsoft Teams

Present	
Richard Medwyn Hughes	Independent Member (Chair)
Hugh Evans	Independent Member
Jacqueline Hughes	Independent Member
Richard Micklewright	Independent Member

In Attendance	
Andrew Doughton	Audit Wales
Dave Harries	Head of Internal Audit, NWSSP
Flur Jones	Internal Audit, NWSSP
Nick Lyons	Executive Medical Director
Molly Marcu	Interim Board Secretary
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Matt Joyes	Deputy Director of Quality
Dr Jim McGuigan	Deputy Executive Medical Director
Michelle Phoenix	Financial Audit Manager, Audit Wales
Neil Rogers	NWSSP
Narissa Venables	Finance Trainee
David Seabrooke	Interim Assistant Director of Governance
Steve Webster	Interim Executive Director of Finance

Agenda Item	Action
AC23.01: Opening Business and Apologies for Absence The Chair welcomed Members and attendees to the meeting, including Steve Webster, Interim Director of Finance.	
AC23.02: Declarations of Interest Jacqui Hughes declared her interest in the audit report on the charity as chair of the Charitable Funds Committee.	
AC23.03 – Minutes: 24 August 2022 The Committee approved the minutes of the meeting in public held on 24 August 2022.	

AC23.04: Action log The updated Action log was circulated. The following updates were noted. **AC22.60: Performance Accountability Report (PAF)** it was agreed that the focus would be to put this in place for 2023/24 **AC22.65.5 -** PFIG had discussed this matter	
AC23.05: Record of Breaches of Publication of Committee Papers Three reported breaches were noted.	
AC23.06: Issues discussed in Previous Private Session **AC23.06.1** The report of matters disposed of at the 30 June 2022 private meeting was noted.	
AC23.07: Withdrawn: Chair's Assurance Report: Risk Management Group **AC23.07.1** This was going to be reported to the Quality Safety and Experience Committee,	
AC23.08 Internal Audit Progress Report **AC23.08.1A** The circulated progress report summarised twelve assurance reviews finalised since the last Committee meeting, with the recorded assurance rating as follows: **Substantial** Welsh Information Governance Toolkit Management of utility usage, expenditure and efficiency **Reasonable** Voluntary Early Release (VER) Scheme Chair's actions Speak Out Safely Follow Up – Audit Wales: Effectiveness of Counter Fraud Arrangements Follow up – Audit Wales: Continuing Healthcare Arrangements **Limited** Welsh Language Commissioner: Documents on the Website Effective Governance – Ysbyty Gwynedd Effective Governance – Ysbyty Wrexham Maelor Board and Committee Reporting Charitable Funds	

Themes arising from recommendations included governance and compliance with risk management requirements. The Health Board was not meeting the target for the provision of management responses to completed reviews within 20 days. The need for project managers to engage early with capital audit was highlighted. **AC23.08.2** Fieldwork was underway for 2022/23 reviews as follows: • Data analysis – Concerns/ Complaints/ Incidents/ Never Events/ HIW reports/ Risk register/ Medication errors/ Regulation 28s • Digital Strategy • Urgent Primary Care Centres • Mental Health and Learning Disabilities • Performance Management • Budgetary Control: User Access and Delegated Limits • Decarbonisation **AC23.08.3** It was agreed that future internal audit programmes would be set out for periods of six months, rather than twelve. This would continue to be on the basis that there was a twelve month programme sufficient for the audit Opinion to be given. On budgetary controls, the review of the scheme of reservation and delegation (SoRD) would be aligned to this work. **AC23.08.4** Table 4 of the report set out four planned reviews for 2022/2,3 which following a risk-based assessment with the Interim Board Secretary were proposed to be deferred: Fire Safety, Targeted Intervention, People & OD Strategy, and GP Out of Hours – this was agreed. Table 6 detailed the overall core plan and status. **AC23.08.5B** The Committee received in full the following limited assurance reviews: **AC23.08.5C Effective Governance – Ysbyty Gwynedd (YG)** The Committee received this limited assurance review. The principal findings included a backlog of risk reviews and complaints, and governance meetings either not occurring, or not receiving sufficient assurance. The Chairman welcomed Neil Rogers, Integrated Health Community (IHC) Director of Operations (West). The Committee was reminded that during the pandemic a number of regular governance meetings in line with the decisions of the Health Board Management Team had been stood down and had been resumed in autumn 2022 following the implementation of the Integrated Health Communities. It was noted that governance infrastructure was being developed across the IHC to address finance and performance. Clinical audit had re-started in 2022/23.	MM

There was concern about the achievement of savings and the need to strengthen reporting to the corporate level It was agreed that the Audit workshop would discuss the ongoing monitoring and review of the IHCs.	
AC23.08.5D Effective Governance - Wrexham Maelor Hospital The Chairman welcomed Naomi Holder, Site Director of Nursing (Secondary Care EAST) to address the report. The Committee was reminded of the principal findings: • Instances where risks had not been reviewed • Backlog of Ombudsman issues • Monitoring of clinical audit • Generation of savings proposals • Meeting terms of reference out of date It was noted that the implementation of the integrated Health Community was continuing and was being improved and streamlined; learning had been applied to the development of the structure. It was acknowledged that savings targets were not being met. The IHC was focused on the delivery of high quality care with the aim of reducing from risk and harm. The locality had its share of recruitment issues as workforce could move in and out. The limited assurance finding in relation to complaints was highlighted and the judgement was confirmed. The Interim Director of Finance welcomed the description of the IHC management team getting to grips with financial matters.	
AC23.08.5E Welsh Language Commissioner - Documents on the Website The Chairman welcomed Helen Stevens-Jones, Director of Communications and Engagement to the meeting, who expressed her disappointment in the finding and confirmed that she had asked her team to address the issues found. She acknowledged the need to provide confidence to local Welsh speaking communities. Four of eight actions were already completed. The report had identified inconsistencies between the Welsh and English versions of the Health Board website, including at least one telephone number. There appeared to be limited controls over the review of the Welsh version of site.	
AC23.08.5F Board and Committee Reporting The main findings of the report were as follows:	

• Quality of reports presented was variable • It was difficult to find evidence of scrutiny of draft reports • The response to the finding on the completion of the breach log was not considered to address the risk • Cycles of business had not been reviewed and approved • Publication of agendas on the website was inconsistent The Interim Board Secretary reminded the Committee that a Protocol was in place to ensure timely review of draft Board papers. This was supplemented by the three lines of defence. The Terms of Reference and Cycle of Business would be reviewed with Committee chairs later in Q1. There would also be a round of committee effectiveness reviews.	MM
AC23.08.5G Charitable Funds The principal findings of this report were: Charitable Funds Committee is not operating as intended, with several meetings cancelled due to lack of availability of Members. There has been no formal review of Committee effectiveness or whether the structure meets the Corporate Trustees' assurance requirements. A survey of Health Board members (Trustees) highlights several issues, including a lack of information provided to the Corporate Trustee The Strategy for the Charity has not been formally approved by the Corporate Trustee. Charity objectives stated on the governing document and registered with the Charity Commission are not aligned with some spend. The Charitable Funds Committee had had a presentation at its October meeting and further workshops were planned. The Terms of Reference were being updated and support to the Committee was being improved. It was noted that there was an action plan in the Finance department. It was noted that the Charity did not employ staff – staffing was provided by the Health Board under an agreement. There was a change in how charities were regulated that was being addressed. The role of the Charity would be discussed at the Audit Committee Workshop in May.	MM
AC23.09 Audit Wales **AC23.09.01** The Committee received the report, which included the following reviews: • Tackling the planned care backlog • Public Sector readiness for net Zero Carbon • National Fraud initiative in Wales • Equality Impact Assessments: more than a tick box exercise?	

It was noted that Audit Wales intended to issue the draft Board Effectiveness review by the end of January. **AC23.09.02** In terms of ongoing work, Follow-up Outpatients, Orthopaedic services – follow up and Audit of the 2021-22 Funds Held on Trust Accounts would be shortly reported. **AC23.09.03** The update on Planned care/Waiting Lists discussed the changes to the pattern of referrals during the pandemic period and after. There remained challenges to separating schedule and unscheduled care and workforce challenges. There were variations in anticipated timescales across specialties and localities. Recommendation 5, actively managing the range of risks associated with long waits, was highlighted. **AC23.09.04** The review of Equality Impact Assessments had identified some areas of good practice and also opportunities for organisations to improve in this area. The report considered whether the assessments were developed at the right stage in the decision-making process and whether post-implementation reviews were carried out. The work of the Health Board's policy board was highlighted. Audit Wales agreed to provide some individual examples of good practice. **AC23.09.05** The review of Public Sector readiness for net Zero Carbon by 2030 highlighted uncertainty about achieving the stated ambition. **AC23.09.06** The National Fraud Initiative (NFI) for 2020-21 had helped identify £6.5m of fraudulent activity. It was confirmed by the Interim Director of Finance that the Health Board took part in the NFI. There were three recommendations encouraging all public bodies to make use of the information available from the NFI. It was confirmed that the NFI was non-chargeable.	FJ/ AW
AC23.10 Clinical Audit Plan 2022/23 Q1 and Q2 **AC23.10.01** The Committee received a report outlining the improvement plan for the wider clinical effectiveness agenda and building on the audit program for 2022/23, and evidencing progress with audit plans. **AC23.10.02** The Executive Medical Director described the actions in re-starting the learning and improvement process following the pandemic. The transition to the IHCs meant that significant improvement would start to be seen in 2023/24. There were signs of learning taking place. **AC23.10.03** The Executive Medical Director highlighted a report going to March QSE Committee about reporting arrangements for clinical effectiveness. Quality leads had arrangements for engaging with doctors' professional groups. There was limited assurance because of individual employee appraisal confidentiality.	

AC23.10.04 The Head of Internal Audit suggested that the clinical audit function should be guided by the corporate risk register, which itself was light on clinical risk.	
AC23.11 Performance Accountability Framework Report **AC23.11.01** The Interim Director of Finance suggested that the framework should be developed for 2023/24. The Board Secretary suggested that this issue should be picked up at PFIG.	SW
AC23.12 North Wales Dental Services Assurance Report **AC23.12.01** The Committee received a report from the Executive Director Integrated Care Services. The Chairman welcomed Dr Jim McGuigan to the meeting. The report outlined changes to the way that dental contract was changing in 2023 and the performance and contract monitoring that would apply in the first year of operation. The new approach put more emphasis on prevention and treatment of patients with poor oral health. **AC23.12.02** It was agreed that any updates on this matter should no longer be reported to the Audit Committee, but should come to PFIG.	NL
AC23.13 Schedule of Closed Claims Over £50,000 - Quarter 2 2022/23 **AC23.13.01** The Committee received a report setting out total payment information for claims against the Health Board with a spend of over £50,000 closed during Quarter 2 (July - September 2022) of the 2022/23 financial year. **AC23.13.02** The Chairman welcomed Matt Joyes to the meeting. It was confirmed that the payments had got the appropriate authorisations and the Welsh Risk Board assessment and learning process. The report was noted.	
AC23.14 Issues of Significance for reporting to Board **AC23.14.01** The Chairman confirmed that the Limited Assurance reports reported today would be escalated to the Board: Welsh Language Commissioner: Documents on the Website Effective Governance – Ysbyty Gwynedd Effective Governance – Ysbyty Wrexham Maelor Board and Committee Reporting Charitable Funds	**MM**
AC23.15 Date of Next Meeting: 21 March 2023	

Date of Meeting	Agenda Item	Minute Reference
13-Jan-23	Internal Audit Progress Report	AC23.08.1A
13-Jan-23	Internal Audit Progress Report	AC23.08.3
13-Jan-23		
13-Jan-23	Board and Committee reporting	AC23.08.5F
13-Jan-23	Charitable Funds	AC23.08.5G
13-Jan-23	Audit Wales - Equality Impact Assessment	AC23.09.04
13-Jan-23	Performance Accountability Framework	AC23.11.01
13-Jan-23	North Wales Dental Services Assurance Report	AC23.12
13-Jan-23	Issues of Significance for reporting to Board	AC23.14

Action	Owner
Remind colleagues engaged with capital projects to engage with the capital audit team	Interim Director of Finance
It was agreed that future internal audit programmes would be set out for periods of six months, rather than twelve.	Interim Board Secretary
Set date for Audit C'ttee workshop in May and review committee effectiveness / terms of reference	Interim Board Secretary
The Terms of Reference and Cycle of Business would be reviewed with Committee chairs later in Q1. There would also be a round of committee effectiveness reviews	Interim Board Secretary
The role of the Charity would be discussed at the Audit Committee Workshop in May.	Interim Board Secretary
Audit Wales agreed to provide some individual examples of good practice.	Audit Wales
Finalise the Performance Assessment Framework for 2023/24 and take it through PFIG	Interim Director of Finance
It was agreed that any updates on this matter should no longer be reported to the Audit Committee, but should come to PFIG.	Executive Medical Director
The Chairman confirmed that the Limited Assurance reports reported today would be escalated to the Board	Interim Board Secretary

Action Due Date	RAG	Progress update
01-Jan-23		
15-May-23		**UPDATE: MARTY MCAULEY** New Audit Programme is 6 months and not 12
01-Feb-23		**UPDATE: MARTY MCAULEY** This action remains outstanding due to the change in membership. New date to be set
30-Jun-23		**UPDATE: MARTY MCAULEY** Marty and Karen to meet on XXXand agree
15-May-23		**UPDATE: MARTY MCAULEY** This action remains outstanding due to the change in membership. New date to be set
15-May-23		
21-Mar-23		
15-May-23		
15-May-23		

Status	Date Committee closed action
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	
In progress - unless updated by Marty	

Teitl adroddiad: ***Report title:***	Internal Audit Plan 2023/24 - April to September 2023 Internal Audit Charter Internal Audit Progress Report 1st January 2023 - 30th April 2023
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	
Crynodeb Gweithredol: ***Executive Summary:***	The audit plan for 2023/24 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. The internal audit plan for April to September 2023/24 details the risk based planned reviews for the first six months of the financial year following review of Board and Committee papers; Board Assurance Framework; Corporate Risk Register; risk based meetings with Independent Members and Executive Directors; and reviews deferred from 2022/23. The six-month plan format was agreed by the Audit Committee and Interim Chief Executive (Accountable Officer) to ensure internal audit focus on areas of emerging risks facing the Health Board. The progress report is produced in accordance with: • the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. • the Board and required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report summarises seven assurance reviews finalised since the last Committee meeting in January 2023, with the recorded assurance as follows: • Reasonable assurance (yellow) – four; • Limited assurance (amber) – one; • No assurance (red) – one; and • Advisory (grey) – one. The report also details the reviews with reports issued as draft, work in progress and recommendations subject to follow-up in the period.
Argymhellion: ***Recommendations:***	The Committee is asked: **Plan** • To approve the six-month Internal Audit Plan for April to September 2023. • To note the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2023/24. • To note the gap in resource requirement to deliver the increase in assurance requested by the Health Board Audit Committee. • To approve the Internal Audit Charter. • To note the associated Internal Audit Key Performance Indicators. **Progress report** • To receive the progress report. • To approve the recommendations to defer three reviews from the plan.
Arweinydd Gweithredol:	Interim Board Secretary

Executive Lead:				
Awdur yr Adroddiad: ***Report Author:***	Head of Internal Audit Deputy Head of Internal Audit			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This progress report is required in accordance with 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).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. The audit plan for 2023/24 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. This progress report is required in accordance with 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).

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews / recommendations. We have requested but not been provided with a copy of the Ernst & Young report concerning the review into issues surrounding financial control. There is a high risk that weaknesses in control are not considered or included within the internal audit plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews / recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The progress report is produced independently of management. Progress report shared with the Interim Board Secretary for review.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The six month internal audit plan and progress report is presented in accordance with the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Internal Audit Plan 2023/24 - April to September 2023 • Appendix 2: Progress report • Appendix 3: Delivery of Health Board Savings • Appendix 4: Urgent Primary Care Centres – Business case outcomes achieved	

Internal Audit Plan 2023/24 – April to September 2023

Internal Audit Charter

May 2023

Betsi Cadwaladr University Health Board

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

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

Contents

1. Introduction

This document sets out the six-month Internal Audit Plan for the period April to September 2023 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. The rolling internal audit plan includes other areas of risk at the time of development that will be assessed for the last six-months of the year. These were identified as part of the annual risk assessment but are not currently prioritised within the Internal Audit Plan coverage, some of these areas may be considered in future years plans.

It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Public Sector Internal Audit Standards (the Standards) require that *'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'*

Accordingly, this document sets out the risk-based approach, the first six month Plan for April to September 2023 and the audit universe (rolling plan for the period 2018/19 to 2024/25). The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning.

2.2 Risk based internal audit planning approach

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

- the organisation's risk assessment and maturity.
- the organisation's response to key areas of governance, risk

management and control.

- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP), Living Healthier, Staying Well, organisational change, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose through the six-month planning cycle enabling us to focus on any emerging issues throughout the year. The six-month plans will be reported to the Audit Committee in line with the Internal Audit Charter.

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

In addition, we will, if requested, also agree a programme of work through the Board Secretaries network. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

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

2.3 Link to the Health Board systems of assurance

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

- Board priorities in the IMTP.
- Board and Committee papers.
- Executive Directors corporate responsibilities.
- In depth knowledge and understanding of the Health Board.
- Legislative compliance.
- Second line assurance e.g. Local Counter Fraud Specialist, Post Payment Verification Team.
- Other review bodies assurance including Audit Wales & Healthcare Inspectorate Wales; and
- Coverage needed to provide assurance to the Accountable Officer.

2.4 Audit planning meetings

In developing the Plan, the Head of Internal Audit has also met and spoken with several Health Board Executives and Independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

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

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

The Orange Book issued by HM Government outlines the principles and concepts for managing risks in the public sector. The Audit Universe/Rolling plan (Appendix B) has focused on the risk categories as defined within the Orange Book. Whilst the Audit Universe is defined by exposure to risk and associated controls, audit plans will also be cognisant of value for money and performance considerations. The following diagram details HM Government risk topics and how we have aligned these to the Health Board/NHS Wales.

Corporate Governance and Regulatory Risks *(Corporate Governance, Risk Management and Regulatory Compliance)*

Risks arising from unclear plans, priorities, authorities and accountabilities, and/or ineffective or disproportionate oversight of decision-making and/or performance e.g.

- Corporate governance including governance & accountability module
- Risk management and assurance including annual governance statement
- Corporate legislative requirements

Strategic Risks *(Strategic Planning, Performance Management & Reporting)*

Risks arising from identifying and pursuing a strategy, which may have been poorly defined, is based on flawed or inaccurate data or fails to support the delivery of commitments, plans or objectives due to a changing macro-environment e.g.

- Strategic planning
- Healthcare commissioning and contract management

Financial Risks *(Financial Governance and Management)*

Risks arising from not managing finances in accordance with requirements (e.g. Nolan Principles) and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting e.g.

- Financial planning and budgetary control
- Financial recovery and cost improvement plans
- HB/SSP managed financial systems

Clinical Governance Quality and Safety Risks *(Quality & Safety)*

Risks arising from ineffective quality procedures and failure to safeguard patients, staff and the general public e.g.

- Health and safety management
- Clinical governance, standards and clinical audit
- Medicines management
- Infection control and prevention
- Complaints, claims and serious incidents

Technology Risks *(Information Governance and Security)*

Risks arising from technology not delivering the expected services due to inadequate or deficient system/process development and performance or inadequate resilience e.g.

- Information governance
- Records management including Caldicott guardian
- Data quality
- Information management and technology, including disaster recovery

Operational Service and Functional Management Risks *(Operational Service and Functional Management)*

Risks arising from core function of the organisation, including alignment with the overall strategy e.g.

- Directorates, departments and services
- Localities and community hospitals
- Primary care services
- Hosted organisations

Workforce Management Risks *(Workforce Management)*

Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, insufficient workforce capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance e.g.

- Payroll / ESR/ recruitment
- Workforce planning
- Organisational development and training

Project/Programme Risks *(Capital & Estates Management)*

Risks that change programmes and projects are not aligned with strategic priorities and do not successfully and safely deliver requirements and intended benefits to time, cost and quality.Environmental sustainability management and reporting e.g.

- Capital funded programmes/ projects
- Unconventionally funded programmes/ projects.

Property Risks *(Capital & Estates Management)*

Risks arising from property deficiencies or poorly designed or ineffective/ inefficient safety management resulting in non-compliance and/or harm and suffering to employees, contractors, service users or the public e.g.

- Fire safety management
- Asbestos management etc.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24 (April to September 2023)

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 appraised 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.

4.2 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.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

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

During the risk planning meetings, we have been asked to provide more

assurance to the Health Board. With our current resource a limiting factor, the Director of Audit and Assurance has contacted the Interim Board Secretary and await to agree a way forward.

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.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for April to September 2023/24 and:

- approve the six-month Internal Audit Plan for April to September 2023;
- note the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2023/24;
- note the gap in resource requirement to deliver the increase in assurance requested by the Health Board Audit Committee;
- approve the Internal Audit Charter; and
- note the associated Internal Audit Key Performance Indicators.

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 2023/24 – April to September 2023

Planned output, Outline scope, Review reference	Strategic Objective (SO) and BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
Corporate Governance and Regulatory			
Contract award and management – We will review the process for awarding contracts across the Health Board along with contract management arrangements.	Executive request	Board Secretary	May
Strategic			
No specific risk identified for coverage in April to September 2023	-	-	-
Financial			
Financial Control: Receipting of goods and year-end accruals – We will review whether the internal financial controls for purchase order accruals is robust and whether the Health Board's own Standard Operating Procedure is complied with.	SO 2 BAF Risk 2.3 - score 16	Director of Finance & Performance	April
Accounts Receivable – We will review key controls for the receipt, banking and debt management in accordance with standard operating procedures and Standing Financial Instructions.	SO 2 BAF Risk 2.3 - score 16	Director of Finance & Performance	June
Clinical governance, Quality and Safety			
Clinical Audit: Tier 1 National Audits – We will review the Health Board's participation with Tier 1 audits, including the submission of data and resulting actions.	SO 1 – BAF Risk 1.2 - score 20	Medical Director	April

Falls management – We will review compliance with Policy NU06 - The Prevention and Management of Adult In-Patient as well as the reporting and management arrangements in place.	SO 4 BAF Risk 4.1 - score 20	Director of Nursing & Midwifery	June
Lessons learned – We will review whether lessons learnt are shared across the Health Board from Regulator reports through complaints, including learning from reports submitted to the Welsh Risk Pool.	SO 4 BAF Risk 4.1 - score 20	Director of Nursing & Midwifery	July
Technology			
Cyber security – We will review the implementation of the improvement plan and the accuracy of reporting.	CRR 21-11 – score 20	Chief Digital and Information Officer	April
Digital Operating Model – We will review what steps have been taken to *"Developing proposals for a new operating model for how we deliver Digital, Data and Technology Services as a Health Board"* as detailed in *Our Digital Future – Digital Roadmap for Health in North Wales 2021-2024.*	SO 2 BAF Risk 2.5 - score 16	Chief Digital and Information Officer	June
Operational service and Functional management			
GP Out of Hours (Deferred from22/23) – We will review the Health Board's progress against the Peer review action plan, and consider reporting arrangements for assurance.	SO 3 BAF Risk 3.3 - score 16	Director of Integrated Health Care	April
Workforce management			
Workforce Strategy: Operational implementation (Deferred from 22/23) - Working with colleagues in People & OD, we will review the delivery and progress by Health Communities, Regionally Managed Services and Service Support Functions in delivering the strategy.	SO 2 BAF Risk 2.1 - score 16	Director of People & OD	May
Project/Programme			

Decarbonisation – We will review steps taken to progress the Decarbonisation Action Plan and confirm ownership of progress.	SO 3 BAF Risk 3.1 - score 16	Director of Finance & Performance	July
Adult and Older Persons Mental Health Unit (IAAP) - The focus of the review will include, for example, governance, contractual appointments, and design development.	BAF Risk 3.1 - score 16	Director of Finance & Performance	April to September
Property			
Corporate Legislative Compliance: Water Safety – We will review compliance with the Policy for the management of safe water systems (ES02) and Welsh Health Technical Memorandum 04-01 *Safe water in healthcare premises*.	SO 4 BAF Risk 4.1- score 20 CRR 20-03 – score 16	Director of Finance & Performance	May

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	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Corporate governance, risk, and regulatory compliance							
Welsh Language Measure (Wales) 2011		Limited			Limited		
Board Assurance Framework & Risk Management	Reasonable		Reasonable	Reasonable	x	Ⓡ	Ⓡ
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Limited					Ⓡ	
Corporate Legislative Compliance: Social Services and Well-being (Wales) Act 2014							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
COVID-19 Governance & Associated reviews			Assurance not applicable*2	Assurance not applicable*2			
Corporate Legislative Compliance - Civil Contingencies Act 2004							
Partnership governance		Limited		Limited		Ⓡ	
Regional Partnership Board/Integrated Service Board				Limited			
Standards of Business Conduct - Declarations of interest, gifts, and hospitality	Reasonable			Limited		Ⓡ	
Board, Executive, Divisional Governance	Limited		Limited	Assurance not applicable	Limited	Ⓡ	
Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation (SORD)					Reasonable	Ⓡ	
Policies & Procedures						Ⓡ	
Targeted Intervention				Reasonable			
Impact Assessments		Limited		Reasonable			
Welsh Risk Pool – Claims Management		Reasonable	Substantial				

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Annual Report/Annual Governance Statement	Reasonable		Assurance not applicable				
Preparations for EU Exit (BREXIT)			Assurance not applicable				
Strategic risk							
Performance management & Reporting			Reasonable		x	Ⓡ	Ⓡ
Strategic planning - Including IMTP						Ⓡ	
Annual Operational Plan	Reasonable						
Business Continuity Planning/Arrangements	Limited		Limited	Limited			Ⓡ
Healthcare Commissioning					x		
Transformation / Project Management					x		Ⓡ
Communication and Stakeholder engagement						Ⓡ	
Financial risk							
Asset management						Ⓡ	
Benefits Realisation						Ⓡ	
Budgetary Control & Financial reporting	Reasonable	Reasonable	Reasonable	Reasonable	x	Ⓡ	Ⓡ

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Business Case - Capital and Revenue	Limited					Ⓡ	
Accounts Receivable - Cash and Bank/Petty Cash/Cash receipting						✓	Ⓡ
Charitable Funds					Limited	Ⓡ	Ⓡ
Costing							
Counter Fraud					Reasonable		
Financial planning/Sustainability							
General Ledger						Ⓡ	Ⓡ
Lease Cars							Ⓡ
Losses and Special Payments						Ⓡ	
Standing Financial Instructions - Procurement	Reasonable	Reasonable*2		Reasonable		✓	Ⓡ
Private / Overseas Patients						Ⓡ	
Patients Monies and Property	Limited	Assurance not applicable	Assurance not applicable				
Payment Card Industry Compliance							Ⓡ
Savings - Identification and Delivery	Reasonable		Limited		No	Ⓡ	Ⓡ
Stores							Ⓡ
Value Based Healthcare					x		
Year-end processes						✓	

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Clinical governance quality & safety							
Annual Quality Statement	Reasonable	Reasonable	Reasonable				
Clinical audit				Limited		✓	
Clinical coding	Assurance not applicable						
Clinical Commissioning - Quality & Safety							
Corporate Legislative Compliance: Health and safety at Work etc. Act etc. Act 1974		Reasonable	Assurance not applicable			Ⓡ	
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020						Ⓡ	
Deprivation of Liberty Safeguards (DOLS)		Limited				Ⓡ	
Decontamination		Limited					Ⓡ
End of Life Care							Ⓡ
Follow-up Healthcare Inspectorate Wales				Assurance not applicable			

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
HASCAS & Ockenden Follow-up		Reasonable	Reasonable	Assurance not applicable			
Incident management							
Infection Prevention and Control	Reasonable					Ⓡ	
Medical equipment and devices							
Nutrition and Hydration	Limited						Ⓡ
Patient experience						Ⓡ	
Patient Safety Notices etc			Reasonable				
Public Health					x		Ⓡ
Concerns/Complaints/Putting things right/Learning Lessons	Limited			Reasonable	x	✓	Ⓡ
Quality Improvement Strategy		Limited				Ⓡ	
Research and Development							Ⓡ
Safeguarding		Substantial					
Security			Limited	Assurance not applicable			Ⓡ
Ward accreditation						Ⓡ	
World Health Organisation (WHO) Checklist							Ⓡ
Technology							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Informatics governance	Assurance not applicable		Assurance not applicable				
Digital Strategy / Digital Operating model					Reasonable	✓	Ⓡ
Digital readiness							Ⓡ
Service Management (ITIL)						Ⓡ	
Access Controls							
Identity and certificate management							
Cyber security		Reasonable		Reasonable		✓	
Change Control							
Data analytics / data led organisation							Ⓡ
Business process automation / robotics						Ⓡ	
IT equipment / end user device management						Ⓡ	
IT infrastructure / network management (inc. NIS Directive)				Reasonable		Ⓡ	
IT Projects						Ⓡ	
Software / system development							
Disaster recovery and resilience			Limited				Ⓡ

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Cloud migration							
Medical records management, control, and access							Ⓡ
Patient records & Digital Integration / digitisation						Ⓡ	
Safe Care							
Data quality							
Corporate Legislative Compliance: Freedom of information Act	Reasonable						Ⓡ
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							
Wellsky Pharmacy Management System						Ⓡ	

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Oracle E-financials							
PACS & Radis							
Welsh Clinical Portal							
Welsh Demographic Service							
WPAS							
Operational service and functional management							
Bereavement Services							
Integrated Health Community - Central				Assurance not applicable		Ⓡ	
Integrated Health Community - East	Reasonable				Limited		Ⓡ
Integrated Health Community - West					Limited		
Cancer Services							Ⓡ
Womens Services				Reasonable		Ⓡ	
North Wales Managed Clinical Services							
Mental Health and Learning Disabilities	Limited / Assurance not applicable	Assurance not applicable	Limited	Assurance not applicable	x		

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Cluster management and development				Reasonable			Ⓡ
Clinical Trials							
Discharge / Patient Flow management						Ⓡ	
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	Assurance not applicable					✓	
Looked After Children (LAC)							
Managed GP Practices		Reasonable				Ⓡ	
Medical Physics							
Non-Emergency Patient Transport Service		Reasonable					
Operational Estates and Facilities	No assurance						Ⓡ

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Primary Care – Transformation Fund/Other	Limited						
Transport Management							Ⓡ
Unscheduled care – Six Goals for Improvement						Ⓡ	
Waiting list management	Limited			Limited		Ⓡ	
Planned care delivery					x		Ⓡ
Prison Healthcare Services							
NHS Wales Act - Section 33 Agreements		Limited					Ⓡ
Veterans							
Workforce management							
Agency Staffing/IR35			Limited			Ⓡ	
Annual leave							
Approved Clinicians and Section 12(2) approval			Reasonable				
Case Management & Disciplinary process	Limited					Ⓡ	
Corporate Legislative Compliance: National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005						Ⓡ	
Consultant Contract/Job planning							Ⓡ

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Consultant Revalidation							Ⓡ
Staff Benefit Schemes							
Corporate Legislative Compliance - Equality Act 2010							
Roster management			Limited	Limited		Ⓡ	
Job evaluation							
Manual Handling							
Medical Staffing				Reasonable			
NHS Wales Staff Survey		Limited					
Occupational Health							
On-Call				Limited			Ⓡ
Payroll/Salary Overpayments	Limited	Limited					
PADRs							
People & OD Strategy						✓	
Professional Registration						Ⓡ	
Raising staff concerns/Safehaven/Speak out Safely					Reasonable		Ⓡ
Recruitment		Limited		Reasonable	x		
Engagement of Interim appointments			Limited				
Sickness absence management						Ⓡ	
Staff Leavers				Limited			

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Staff wellbeing							
Statutory and mandatory training							
Temporary Staffing							
Upholding Professional Standards in Wales (UPSW)				Reasonable			
Violence & Aggression			Limited				
Voluntary Early Release Scheme (VERS)				Reasonable	Reasonable		
Volunteers							
Waiting list initiative							
Project and programme risk							
Integrated Audit Plans - Major capital schemes assurance	Reasonable	Reasonable*5	Reasonable		x	✓	Ⓡ
Discretionary funded schemes & equipment procurement						Ⓡ	
Capital Systems	Reasonable		Reasonable	Substantial			
Vehicle, Equipment & IT Procurement		Assurance not applicable					
Property							
Corporate Legislative Compliance - Asbestos Management				Reasonable			Ⓡ

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	**Limited**	**Reasonable**	**Reasonable**	**Limited**	**X = Assurance reviews in progress**	**✓ = April - September Ⓡ = Risks identified**	**Ⓡ = Risks identified**
Corporate Legislative Compliance - Fire Safety		Reasonable					Ⓡ
Corporate Legislative Compliance - Water Safety			Limited			✓	
Medical Gases							
Electricity Safety Regulations						Ⓡ	
Backlog Maintenance							
Minor works							
Maintenance and operations							
Control of Contractors			Limited				
Waste Management				Reasonable			
Residential Accommodation							Ⓡ
Property management	Limited				Substantial	Ⓡ	
Carbon Reduction Commitment Order/Decarbonisation Environmental Sustainability	Substantial Reasonable	Substantial Reasonable	Substantial		Advisory	✓	
Analysis of reviews							
Substantial	1	2	3	1	2	0	0
Reasonable	14	18	9	16	6	0	0
Limited	14	10	12	9	5	0	0
No assurance/Unsatisfactory	1	0	0	0	1	0	0
Assurance not applicable/Advisory	4	3	7	8	1	0	0
TOTAL number of reviews	**34**	**33**	**31**	**34**	**15**		

Appendix C: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2023/24 agreed/in draft by 30 April	✓	100%
Audit opinion 2022/23 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [20 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix D: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

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

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

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

2 Purpose and responsibility

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

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

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

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

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

3 Independence and Objectivity

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

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

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity’s performance relative to its plan.

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

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

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

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

4 Authority and Accountability

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

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

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

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

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

private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

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

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

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

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

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

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

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

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

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards, and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

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

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

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

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

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

8 Approach

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

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales requirements of the Charter.
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment.
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion.
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan.

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

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

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

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

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

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

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

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

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the

relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

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

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 20 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken – Operational management will provide any factual accuracy issues within the first 5 working days;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Board Secretary and placed on the agenda for the next available Audit Committee.

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2023

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Delivery of Health Board Savings
Final Internal Audit Report

February 2023

Betsi Cadwaladr University Health Board

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

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

Contents

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Report status:	Final Internal Audit Report
Fieldwork commencement:	9 November 2022
Fieldwork completion:	15 December 2022
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Management response received:	3 February 2023
Final report issued:	6 February 2023
Auditors:	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit Simon Cookson, Director
Executive sign-off:	Steve Webster, Interim Executive Director of Finance
Distribution:	Rob Nolan, Finance Director Molly Marcu, Interim Board Secretary
Committee:	Audit Committee

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

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

Executive Summary

Purpose

The purpose of the audit was to review the identification and delivery of savings as outlined in the IMTP and associated Financial Plan for 2022/23.

Overview

We have issued no assurance on this area. The significant matters which require management attention include:

- The general ledger recorded a carry-over savings requirement of £13,456,727, which is included in the budget reports of Directorates/Divisions but is not reflected in the recurring savings requirement for 2022/23 or included in the savings requirements reported to the Board. The total savings requirement identified in our review is £48,456,727 in 2022/23. Board reports must be accurate and reflect the actual saving requirement on a recurrent basis.
- There appears to be confusion concerning ownership and delivery of transformational savings as at the time of our review, no transformational savings are being reported against the £17.5m target (reported to Committee in December 2022). The back-end phasing of transformational savings provided a positive picture on savings delivery to month 5, where the focus was delivery of transactional savings.
- The role of the Transformational Team requires review and greater clarity on their purpose and benefit to operational management.
- Corporate functions have, generally, been poor in the delivery of savings; all should be subject to similar accountability/performance scrutiny akin to the rest of the Health Board.
- Voluntary Early Release Scheme (VERS) recurring savings of £622,691, approved by

Report Opinion

		Trend
No assurance 	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Governance and reporting arrangements.	No
2	Savings plans and evidence to support forecast savings.	Limited
3	Operational budgets reduced to reflect delivery of recurrent savings.	Limited

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

Remuneration and Terms of Service Committee, require action and removal from the discretionary revenue allocation, and the establishment adjusted.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Reports to the Health Board do not reflect the complete savings required for 2022/23, inclusive of unachieved previous year recurring savings carried over – The monthly budget reports however include the unachieved savings from 2021/22.	1	Design	High
2	Voluntary Early Release savings have not been actioned in line with Remuneration and Terms of Service Committee approval.	1,3	Operation	High
3	Governance and oversight arrangements in delivery of savings have not been adequate.	1	Design	High
4	Transformational savings have not been identified.	1	Operation	High

1. Introduction

1.1 The Health Board considered the *Integrated Medium-Term Plan* (IMTP), which incorporates the Financial Plan for 2022/25, at its meeting on the 30th March 2022 (Item 22/97). The Financial Plan includes a required savings target of £35m[1] for 2022/23, consisting of £18m Transactional savings and £17m Transformational savings.

The month 5 Finance Report presented to the Health Board meeting on the 29th September 2022 (Item 22.233) advised the Board *that "Savings delivered in the 5 months to August 2022 was £6.5 against a plan of £7.5m, a shortfall of £1.0m. Non-recurrent savings delivered are £2.4m. The savings forecast is £14.4m, which is £20.6m behind the target of £35m for the year. There were no transformation savings either planned or delivered in the first five months of the year."*

The report also records *"Non delivery of savings"* as having an impact on the reported overspend of £2.7m (as at month 5) in divisional performance.

1.2 The risks considered were:

- Health Board does not achieve a balanced financial position as it is forecasting and reporting to Board.
- Health Board breaches its Statutory Duty to break-even.

1.3 The review was limited to the identification, delivery and reporting of savings plans only and has not considered budgetary control or financial management arrangements.

1.4 We have not reviewed the arrangements the Health Board has put in place since the September 2022 Board Meeting or the arrangements governing the recovery plan.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We would like to express our gratitude to all Officers 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.

Objective 1: Governance and reporting arrangements concerning the allocation and oversight of savings delivery

2.1 The detailed findings relating to the nineteen officers we contacted and respective findings are detailed in Appendix B.

2.2 The Health Board approved an annual savings target of £35m for 2022/23, split evenly between transactional and transformational savings and with a requirement for the savings to be cash releasing. Reviewing the IMTP Financial Plan for 2022/23,

[1] Source: Integrated Medium-Term Plan 2022/25 – Finance and Value, page 29

we found an immediate shortfall of cash releasing savings - £5m for transactional and £10.3m transformational with insufficient schemes having been identified, with other savings noted as efficiency improvements of £25.7m (these are not cash releasing).

2.3 Health Board reporting has consistently focused on a £35m saving target, however the full savings requirement in 2022/23 was £48,456,727, inclusive of all recurring savings not achieved from 2021/22 (Appendix B provides the detail).

2.4 Budget reports issued to budget holders and the General Ledger report include the recurring savings not achieved from 2021/22 that were carried over.

2.5 The 23 December 2021 PFIG meeting received *Integrated Medium Term Plan (IMTP) – Financial Focus 2022/23 Income and Expenditure Scenarios* (Item PF21.47) that reports *"The majority of negative budgets arising from unallocated savings targets were cleared at the start of 2021/22 and there will be no negative savings targets carried forward into 2022/23."* – Our review has identified this did not happen (please see Appendix B for details).

2.6 The draft timetable containing key dates for developing the 2022/23 Budget Strategy in PF21.47 also records *"31st Jan 2022 - Three year transformational savings plan developed"*. We confirmed with the Director Transformation, Strategic Planning, and Commissioning that there are no transformational savings plans in place (as of 20 December 2022).

2.7 Management back-ended the phasing and expected delivery of the nine transformational savings from September 2022 to March 2023 (Table 1). The Head of Financial Reporting notified the Chief Finance Officers that *"The projected delivery profile has now been received. Please can you re-profile the Transformational element of your CRES budget accordingly? (The Transformational element you have been allocated is 50% of you original CRES allocation). The risk of such a back ended delivery has been noted and is being raised at the highest level by [Officer] and the Senior Team".*

Table 1: Phasing of the £17.5m Transformational savings

Month	In month saving (£m)
Apr-22	-
May-22	-
Jun-22	-
Jul-22	-
Aug-22	-
Sep-22	0.25
Oct-22	0.50
Nov-22	1.00
Dec-22	1.75
Jan-23	3.00
Feb-23	4.50
Mar-23	6.50
Total	17.50

Source: Extract from email sent by the Head of Financial Reporting to Chief Finance Officers on the 27 May 2022.

2.8 Transformational savings are based on historical reported opportunities for savings. Through discussions with Finance colleagues, it became apparent Chief Finance Officers (CFOs) were not involved in their identification, calculation or whether they were achievable in 2022/23. We were also advised that whilst Finance have regular dialogue with respective management teams, this is not the case for the Transformational Team.

2.9 On the 19 January 2023, we received evidence of email correspondence dated 24 January 2022 issued from the Directors' of Finance; and Transformation, Strategic Planning, and Commissioning to Directors and senior officers of the Health Board which outlined the *"…need to pull together plans to deliver our savings targets through combination of transactional and transformational change, building upon the innovation shown during the past year. To achieve this, we require all Directorates and Divisions to submit a schedule of their savings programmes for 2022-23, which in total for the Health Board must reach £35m of recurring, budget reduction savings."* We found no evidence that this requirement was complied with.

2.10 The Performance Finance and Information Governance Committee (PFIG) Agenda Item PF22.11b reports that between April and June 22 *'Executive team led 'star chamber' assessment and assurance review of divisional/directorate plans – part 2'* and 30 June 2022 *'100% savings targets identified and internally assessed'*. On the 19 January 2023, we received evidence of a Savings and Transformation Update paper to a Star Chamber Meeting on 30 June 2022 – We are unsure whether the Star Chamber took place or seen the outcome from the meeting to evidence actions taken/effective scrutiny of the plans, with the 30 June 2022 timeline not achieved - At the time of this review there remains a significant gap in savings identification.

The 22 December 2022 PFIG Committee received Item PF22/183 *Recovery Programme: Savings 23/24 Summary* that advised the Committee "delivered £9m of recurrent savings in 22-23 with no transformation savings".[2]

2.11 Our request for evidence by the 9 November 2022 resulted in the following high-level analysis:

- VERS applications approved by Remuneration and Terms of Service Committee had not been actioned and recurring funding removed from the discretionary budget, recognising some officers remain in post at the time of this review.
- Some Corporate Director budgets had no evidence of finance plans in place and most had carry-over savings to achieve in addition to the current

[2] Source: Savings 2022- 23 and 2023-24 Update, Slide 4 https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/performance-finance-and-information-governance-committee/pfigc-agenda-221222-v20-public/

requirement. We also noted that one savings target was cleared through the use of reserves.

- Integrated Health Communities (IHCs) have continued their legacy governance arrangements in the absence of revised structures; significant gaps remain in their savings plans and limited progress has been made since the initial plans were submitted.
- Focus for all front-line services has been transactional savings with a widely held view that transformational savings were being taken forward by the Transformational team.
- We found no evidence that the workforce strategy was being considered as a lever for reviewing delivery of/future service needs, thus providing opportunities for service redesign/transformation.
- Two corporate functions advised they had implemented approved business cases but the funding for these had not been included in their baseline allocation.

2.12 Arrangements in corporate functions noting savings discussions, akin to Minutes in IHCs/Divisions, were not available. Whilst we have accepted replies advising discussions do take place, we are unable to corroborate this assertion.

Conclusion:

2.13 Reports provided to the Health Board on savings have under-reported the general ledger cash releasing savings requirement, as the recurring savings carried over from 2021/22 have not been included. Therefore, the Board has been considering a savings target of £35m when the actual target for the Health Board is £48m.

2.14 Transformational savings in 2022/23 were optimistic as the foundations for change require significant lead-time to underpin service redesign. It remains unclear what steps were taken at month one to drive the savings schemes/confirm they remained viable, considering the time-lapse, coupled with the role of the Transformational Team in leading and supporting implementation.

2.15 The back-end phasing of transformational savings from month six is a significant risk to financial balance and this partly explains why the Health Board's forecast year-end position deteriorated in October 2022 - The Health Board was expected to achieve fourteen million pounds (£14m) transformational savings in quarter 4 2022/23.

We did note that finance reports to PFIG in both Month 4 and 5 noted the significant gap in savings still to be achieved of £30.2m and £28.5m respectively. The Chair of PFIG meeting assurance report of the 27 October 2022 escalated the issue of savings delivery to the Board on the 24 November 2022 (Item 22.268).

2.16 We found no VERS recurring savings have been actioned. In addition, considering the impact on workforce generally, limited workforce driven savings are recorded.

We have concluded **no assurance** for this objective as the Health Board has not identified the required cash releasing savings to achieve financial balance.

Objective 2: Review of savings plans identified and evidence to support the reported forecast savings

2.17 We requested savings plans from responsible directors to establish whether divisions and corporate functions had sufficient schemes identified to meet the savings target. We reviewed a total of twenty areas, of these 20:

- Nine had savings plans identified (only one had achieved target)
- Nine did not have savings plans identified (including non-response)
- Two had partial savings plans identified

Further detail is provided in Appendix B.

2.18 We received a list of all savings schemes submitted inclusive of the Month 7 (October 2022) position.

2.19 In obtaining our sample we analysed the data to focus on recurring cash releasing savings of the one hundred and one (101) schemes. Table 2 details the summary of schemes by *Welsh Government/BCU Definition Budget or Run Rate*.

2.20 Table 2 – Summary of Recurring/Non-Recurring Savings schemes by definition

Definition (Please refer to Appendix C for details)	**Non-Recurring**	**Recurring**
Cash Releasing Saving	2	-
Cash Releasing – Budget: Cash releasing saving	9	-
Cash Releasing – Budget: Income Generation	1	-
Cash Releasing – Run Rate: Accountancy Gains	1	-
Cash Releasing – Run Rate: Cash releasing saving	22	-
Cash Releasing – Run Rate: Income Saving	1	-
Cost Avoidance	1	-
Cash Releasing Savings	-	4
Cash Releasing - Budget	-	13
Cash Releasing - Run Rate	-	45
Cost Avoidance	-	2
Total	**37**	**64**

Source: Savings Scheme Detail 07-23 received on the 23 November 2022 from the Savings Accountant.

2.21 We reviewed a sample of five of the thirteen recurring cash-releasing – budget

schemes back to source project initiation documents (PID) where underpinning evidence corroborating the rationale for the scheme was included as well as the method by which the scheme was to be delivered.

Conclusion:

2.22 Management developed PIDs with identified savings which had been actioned by Finance.

2.23 Whilst recurring savings account for most schemes submitted, the number of budgetary recurring savings is limited.

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

Objective 3: Review of operational budgets to confirm they have been reduced to reflect the delivery of recurrent savings

2.24 We reviewed five of the thirteen recurring cash-releasing – budget schemes to verify the value of the scheme and associated budget virement/spreadsheet upload.

2.25 We confirmed that four had been actioned through either a budget virement or a spreadsheet upload due to the volume of budget amendments being actioned. We did not receive a response for one.

2.26 We were also unable to confirm that the Voluntary Early Release Scheme (VERS) recurring savings of £622,691, approved by Remuneration and Terms of Service Committee, have been actioned through budget virement.

Conclusion:

2.27 Four schemes viewed had been actioned in the ledger, however VERS applications had not been actioned for all officers who have left the Health Board at the time of our review.

We have concluded **Limited assurance** for this objective, albeit on the basis of a small sample.

Appendix A: Management Action Plan

Matter Arising 1: Board reporting (Design)			**Impact**
The Health Board's saving target for 2022/23 has consistently reported against the £35m transactional and transformational requirements detailed in the IMTP. The Health Board did not achieve all its recurring savings in 2021/22; these were carried over into 2022/23 but have not been referenced/included in Board reports we have reviewed – The monthly budget reports issued to budget holders and the General Ledger include this information. From data recorded on the general ledger, we have identified that £13,456,727 recurring savings have been carried over into 2022/23 with the Health Board needing to recurrently save £48,456,727 in 2022/23.			Potential risk of: • Incomplete information provided to the Board • Breach of Standing Financial Instruction 5.3.2
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	Reporting 2023/24 from April 2023	Interim Executive Director of Finance

Matter Arising 2: Voluntary Early Release (VERS) recurring savings (Operation)			**Impact**
The Remuneration and Terms of Service Committee approved two rounds of applications submitted by the Executive for consideration and approval, collectively totalling £662,691 of recurring savings. We have not seen any evidence that the recurring savings associated with officers who have already left under VERS have been removed from the operational budgets and the establishment adjusted accordingly.			Potential risk of: • Breach of Standing Financial Instruction 14.1.5
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	Agreed	Immediate	Interim Executive Director of Finance

Matter Arising 3: Effective governance and oversight arrangements to deliver savings (Design)	**Impact**
The IMTP Financial Plan for 2022/23 recorded immediate shortfall of £15.3m (£5m transactional, £10.3m transformational savings). There has been a lack of oversight and scrutiny to ensure: - savings plans have been identified and are sufficient to meet targets identified in the IMTP - accurate reporting to the Board on unachieved recurring savings from 2021/22. Whilst the PID submissions from operational areas were completed, their return suggested a significant gap in the identification of recurring savings early on but there was no apparent impetus or plan to identify further opportunities noting a 30 June 2022 timeline for all savings to be found. Performance Finance and Information Governance Committee (PFIG) Agenda Item PF22.11b advised that between April and June 22 of *'Executive team led 'star chamber' assessment and assurance review of divisional/directorate plans – part 2'* and 30 June 2022 *'100% savings targets identified and internally assessed'.* Savings targets were not achieved by June 2022. Of concern and impacting financial balance was the decision to back-end the phasing of the transformational savings, with £14m expected in January to March 2022 (40% of the total).	Potential risk of: • Breach of Section 175 National Health Service Finance (Wales) Act 2014

Recommendations		**Priority**
3.1a	The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Agreed	April 2023	Interim Executive Director of Finance

Matter Arising 4: Transformational Savings and the establishment of the Transformational Team (Operation)			**Impact**
The savings split between transactional and transformational was not based on any process bar an equal 50:50, consequently it is unclear from the outset whether the transformational savings were ever achievable in 2022/23 or whether they are, as planned, in 2023/24 or 2024/25. Throughout our review, we became aware that operational divisions/services had very little support/input from the Transformational Team to turnaround any delivery of the imposed savings.			Potential risk of: • Breach of Standing Financial Instruction 4.3.4
Recommendations			**Priority**
3.1a	The Health Board: • 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. • Reviews the role of the Transformational Team in driving service change and savings.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Agreed	April 2023	Interim Executive Director of Finance

Appendix B: Detailed findings – Governance and reporting arrangements

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
Chief Executive	41,522	63,000	104,522	(17,026)	No	We were advised that the former Chief Executive made a case that all posts were mandatory and deemed essential – Savings target was funded from contingency reserve and has been overachieved at month 7.
Director of Finance	124,047	313,000	437,047	2,876	Yes	Whilst no minutes/action log of meetings was provided, we did receive details of the savings plan submitted, albeit not addressing the full savings ask but recognise there was a focus to achieve the outstanding balance. We also noted reference to the Voluntary Early Release Scheme (VERS) application that has yet to be actioned (£74,052 recurring saving).

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						We are aware of other VERS posts impacting the discretionary revenue budget which are also not referenced relating to capital, estates and facilities totalling £104,704 which have not been actioned to date as we recognise some officers are still in post.
Board Secretary	22,109	32,000	54,109	22,910	No	Interim Board Secretary advised that there was no savings target for the Office of the Board Secretary, however the ledger reports one. A VERS application for recurring savings of £18,576 is not noted or been actioned.
Director of Public Health	19,189	31,000	50,189	17,019	Partial	Senior Leadership Team agenda includes finance update but we did not receive details of the paper. Plan summary narrative focuses on cost avoidance e.g. bank as

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						opposed to agency staff/reduced travel. We recognise there is a spend to save application concerning the Welsh Language Team been submitted that would increase income generation.
Director of Workforce and Organisational Development (WOD)	202,895	377,000	579,895	236,389	No	No reply to our request for information was received. A VERS application for recurring savings of £22,641 requires action although we are advised that there was no current substantive post/budget and the officer's costs were charged to the OD development programme.
Director of Nursing and Midwifery	183,261	416,590	599,851	202,966	No	We were advised that meetings are held between Finance and Budget Holders but no minutes or actions taken.

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						Whilst outside scope of our review, management advised *"There are a number of historical business cases that have been supported by the HB but the related revenue not aligned to the budget i.e. IPC and Safeguarding , these will be reviewed and options developed to support if no ongoing funding available."*
Medical Director	32,932	86,000	118,932	3,146	No	No savings plan was provided, with reference made to a post being held vacant following retirement; this is a VERS approved application releasing recurring savings of £38,955 which has yet to be actioned.
Director of Therapies and Health Sciences	1,909	11,000	12,909	4,554	No	The Director contacted and advised they was unable to meet our reporting requirements due to a period of sickness absence.

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
Director of Digital	-	553,135^	553,135	354,115	Partial	Savings plan was provided for a scheme in Information Governance. Finance engagement and monthly reporting is evident, but we identified concern over the financial budget including *"...been apparent from some time that despite business cases being approved by Execs with both capital and revenue implications clear within them that the budgets have not been adjusted or funded to meet the requirements. However, the projects have continued and the spend committed. ",* that will impact the ability to identify cash releasing savings. A VERS application for recurring savings of £24,033 is not noted or been actioned.

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
Director of Partnerships/Communications and Engagement	0	24,000	24,000	7,513	Yes	We have seen correspondence advising that the savings have been delivered in full, although the ledger figure indicates a balance outstanding. We saw confirmation of regular dialogue and reporting with Finance.
Director of Integrated Clinical Services (Chief Operating Officer)	10,816	36,000	46,816	32,042	No	No savings plan in place - we were advised this is due to organisational change and the structure below is yet to be finalised with interim appointments in post.
Director of Primary Care and Community Services	330,867	(773,000)^	330,867	-	No	We note that this post is not in the organisational structure but are unsure where the carry over unachieved savings for 2021/22 are being addressed.
Director of Transformation, Strategy and Planning	-	219,865^	219,865	104,686	Yes	Advised finance reports are received monthly and that the Senior Management Team meet

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						monthly to discuss the risk of savings achievement. Savings plans submitted but there is no reference to the two posts subject to VERS delivering £134,271 recurring savings that require action.
Integrated Health Community – Centre	2,077,500	8,893,410	10,970,910	3,024,952	Yes	Legacy governance arrangements were evident as the IHC wait for the new structure to be implemented – we saw an example of financial scrutiny provided through the hospital structure. There was no carry over savings from prior years for the former Area. Evidence of early plans for 2022/23 in place for Area in line with PID submissions but no evidence of new schemes identified in-year. Area added the agreed savings schemes

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						to the budgets thus not having a central line of savings, but no transformational savings were identified as we were advised the original corporate message to Divisions was that these were being taken forward by the Transformation team. Reports show Emergency quadrant have found no savings and it's unclear what steps management are taking to do so. Savings plans submitted but there is no reference to the two posts subject to VERS delivering £44,058 recurring savings that require action.
Integrated Health Community – East	2,918,189	8,251,000	11,169,189	2,791,546	Yes	Legacy governance arrangements were evident as the IHC wait for the new structure to be implemented – Example of financial scrutiny provided through the hospital structure.

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						We noted reference to the view that the Transformation team were leading on the transformational savings. The Area cleared their carry over savings of £1.062m in month 1 2022/23 but we have not corroborated this. Savings plans submitted but there is no reference to the one post subject to VERS delivering £14,130 recurring savings that require action.
Integrated Health Community – West	2,846,423	6,064,000	8,910,423	2,980,222	Yes	Legacy governance arrangements were evident as the IHC wait for the new structure to be implemented – we saw an example of scrutiny through the hospital management structure as well as site accountability meetings where non-delivery and identification of savings in detail within finance reports e.g Emergency Care month

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						4 report states *"This year's savings requirement for Ysbyty Gwynedd is £4.8m (22/23 target £3.1m; b/f savings target £1.7m due to previous non-recurrent delivery). Only £36k savings have been delivered to-date, with forecasted delivery of £563k to year-end"*. The Area Finance, Planning and Performance Group meeting provided pre IHC establishment included focus on savings and the gap *"Submitted 1502 million against target in which we've delivered 392K on the estimated planner 247K so should be on track this year. We have had to do an early days year end forecast for the area and our early day estimates is fairly overspent.."* Plans are evident but the forecast savings appear positive when

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						compared to actual savings delivery. We also received details of all meetings held in November 2022 concerning the identification of savings. Savings plans submitted but there is no reference to the two posts subject to VERS delivering £31,576 recurring savings that require action.
Deputy Director of Integrated Clinical Delivery – Regional Services (Cancer Services/Diagnostics and Clinical Support)	1,450,113	3,586,000	5,036,113	685,297	Yes	Finance and Performance Group meetings evidence received for both Cancer and Diagnostic and Clinical Support (DCS) although due to operational pressures some meetings were deferred. Regular finance reporting and engagement was provided; Cancer savings are patients drugs focused with no other schemes noted. DCS have realised pathology contract savings

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						but there remains a gap in schemes still to find.
Director of Mental Health and Learning Disabilities	341,365	613,000	954,365	(118,783)	Yes	The Division has overachieved its savings requirement and evidence of regular scrutiny was present through Senior Leadership Team – Finance & Performance meetings; we note that it has delivered £1m recurring against Continuing Healthcare but this budget is significantly overspent overall. The division has started reviewing long-term opportunities for savings, but these have no firm calculations identified. There is no reference to the one post subject to VERS delivering £115,695 recurring savings that require action.
Director of Midwifery and Womens Services	127,516	1,375,000	1,502,516	0	Yes	Finance & Performance minutes evidence focus on delivery of

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						savings and regular dialogue with Finance. Finance report details the nine schemes with minimal recurring savings. We note there has been a long-standing IMTP bid to repatriate births from the Countess of Chester which has not been supported despite forecast recurrent cash release savings on the contract.
Deputy Director of Integrated Clinical Delivery – Primary Care	-	-	-	25,503	No	Prior to organisational change, the budget for Community Dental Service was held by the former Central Area and managed by the Area Director. General Dental Services is Welsh Government ring-fenced monies. In response to our request, we received correspondence advising that the post-holder has not been

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						made aware of their budget but we recognise that there is a management structure underpinning the role.
Commissioning Contracts	1,480,000	1,500,000	2,980,000	1,332,980	No	To realise recurrent savings would require contract reduction with operational management providing the service or the Health Board agreeing to stop the commissioned service. Non-recurring savings can be achieved through underspending against the contract.
Other North Wales	100,000	235,000	335,000	-	N/A	Achieved.
Provider Income	-	304,000	304,000	-	N/A	Achieved.
Estates and Facilities	886,180	1,535,000	2,421,180	99,344	No	We did not receive details for Estates from the Executive Director lead as part of their submission. Facilities have been merged into the Integrated Health Communities –

Corporate Function/Division	Unachieved recurring savings budget carried over from 2021/22* **£-**	Savings target budget for 2022/23* **£-**	Total recurrent savings requirement 2022/23 £-	Month 7 position: Year to Date savings budget ** £-	Savings plan evident	Findings/Matters arising through review of evidence provided by 9/11/22
						For the purpose of this report we have shown them separately.
Utilities and Rates	259,894	481,000	740,894	302,205	N/A	We did not receive details for Estates from the Executive Director lead as part of their submission.
Total	**13,456,727**	**35,000,000**	**48,456,727**	**12,094,456**		
Health Board recurring savings requirement 2022/23			**48,456,727**			

Key/Source
* Opening CRES budgets – from budget upload document received on the 23 November 2022 from the Savings Accountant.
** CRES in ledger M7 received 23 November 2022 from the Savings Accountant.
^ Reallocation from the Director of Primary Care and Community Services to Director of Digital and Director of Transformation, Strategy and Planning.

Appendix C: Standard Operating Procedure for Categorisation of Savings and Budgets

National Savings Definitions

The definitions for savings are set out in Welsh Government guidance. These definitions are then applied to categorise savings for the submission of the monthly monitoring return and are held in the **'WG Saving Definition'** column (M) in the savings tracker file. The savings definitions are shown below -

Cost Reduction & Efficiency Savings Definitions		
Term	**Definition**	**Monitoring Returns Classification**
Cash-Releasing Saving (Pay)	A form of cost reduction saving which is workforce related, and specifically relates to providing a service at the same or better quality, for a lower cost, through new ways of working, that reduce cost on an ongoing recurrent basis.	**Expenditure Savings Schemes**
Cash-Releasing Saving (Non-Pay)	A form of cost reduction saving which is non-pay related, and specifically relates to providing a service at the same or better quality, for a lower cost, through new ways of working or reduced prices, that reduce cost on an ongoing recurrent basis.	**Expenditure Savings Schemes**
Cost Avoidance	A form of cost reduction which specifically relates to eliminating or preventing future costs arising. This should be as a result of management action to drive a reduction in costs, for expenditure which is yet to be incurred. Cost avoidance measures may involve some expenditure but at a lower level than predicted future costs.	**Expenditure Savings Schemes**
Income Generation	A form of cost efficiency where an increased contribution to an organisation is generated that can be used for improving services. Income is typically recovered through providing more output from the same cost base, or charging for services provided. Schemes are typically cash generating and not cash releasing schemes.	**Income Generation**
Accountancy Gain	A form of cost reduction which is typically technical in nature, relating to changes in the balance sheet position, or changes in actual expenditure in comparison to previous years estimates or provisions. Savings are typically non-recurrent in nature.	**Accountancy Gain**

What are the BCU Savings Definitions and why are they required?

It is recognised that there is an ongoing need locally to track those cash releasing savings which enable budget reductions, as opposed to pure run rate savings. This allows a clear reconciliation between savings reporting and ledger budget adjustments.

We will therefore maintain the ability to separate these different types of cash releasing savings in our local savings tracking files. The **'BCU Definition'** column (J) has been inserted in the savings file to allow us to do this.

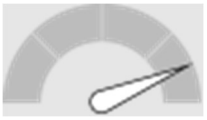
The table below shows how the WG definitions above will map to our local definitions –

WG Savings Definition (column M)	BCU Definition (column J)
Accountancy Gain	Cash Releasing - Run Rate
Cash Releasing Saving	Cash Releasing - Budget Reduction or Cash Releasing – Run Rate
Cost Avoidance	Cost Avoidance
Income Generation	Cash Releasing – Budget Reduction or Cash Releasing – Run Rate
Non Cash Releasing Productivity Gain	Efficiency Gain

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved

Final Internal Audit Report

March 2023

Betsi Cadwaladr University Health Board

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

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

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Executive sign-off:	Gill Harris, Interim CEO/Executive Director of Integrated Clinical Services
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	Joe Lunn - Senior Practice Manager (Healthy Prestatyn Iach) Molly Marcu, Interim Board Secretary Bethan Wassell, Statutory Compliance, Governance and Policy Manager
Committee:	Audit Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

The review has considered whether the reported benefits for UPCCs, as stated in Business Cases / bids, have been realised, and if the Centres are delivering a return on investment made. We have also reviewed how patients have accessed the service.

Overview

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

- The differing models for UPCCs within the Health Board highlight lack of accessibility of the service to some patients. Issues with resource and suitable accommodation also impact on the ability to provide a consistent service to GPs and patients.
- Actual UPCC capacity is significantly lower than intended capacity.
- There is no Benefits Realisation Strategy in place to measure actual performance against benefits outlined in service bids / Business Case.
- The reconciliation of Welsh Government submission information to source data highlights inconsistency in the data.
- Governance Frameworks and Communication Strategies are overdue for review and/or not in place.

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

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	There are appropriate pathways in place for patients to access the UPCCs, with capacity fully utilised. However total actual capacity is significantly lower than intended capacity.	Limited
2	Performance data demonstrates the Urgent Primary Care Centres have reduced pressures within Primary Care services and Secondary Care Emergency Department services.	Reasonable
3	There is oversight of the UPCC service within the Health Board to ensure a quality service is being provided, including a review of capacity, performance data and quality measures.	Reasonable

[1]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	The difference in UPCC models raises issues with accessibility and consistency of the services in some areas.	1	Design	High
2	Actual UPCC capacity does not meet the projected capacity outlined in the service bids / Business Case. There is no formal benefit realisation strategy in place to monitor and measure benefits stated.	1 and 2	Design	High
3	Reconciliation of Welsh Government submitted performance information to source data highlights inconsistencies.	2	Operation	Medium
4	Governance Frameworks and Communication Strategies required updating / completion to ensure continued relevance.	3	Operation	Medium

1. Introduction

1.1 During the last two years, the Health Board has established several Urgent Primary Care Centres (UPCCs) across North Wales as part of the Welsh Government nationally funded programme of innovation. The UPCCs provide on the day access for patients with urgent, non-complex acute episodes that can be managed by primary care. This aims to reduce pressures within primary care and reduce the number of patients who are accessing secondary care/ emergency services.

The purpose of this audit was to review whether the purported benefits of Urgent Primary Care Centres, as approved by the Board, have been realised and are delivering a return on investment. We also reviewed how patients access the service. Objectives of the review were:

- There are appropriate pathways in place for patients to access the UPCCs, and these are resourced sufficiently, with capacity fully utilised.
- Performance data demonstrates the Urgent Primary Care Centres have reduced pressures within Primary Care services and Secondary Care Emergency Department services.
- There is oversight of the UPCC service within the Health Board to ensure a quality service is being provided, including a review of capacity, performance data and quality measures.

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

- Limited access to Urgent Primary Care Centres.
- Lack of patient information regarding Urgent Primary Care Centres.
- Urgent Primary Care Centres under-utilised and operating below capacity.
- No reduction in Primary Care and Secondary Care ED service pressures.

1.3 This report is based upon the information provided by the Urgent Primary Care Centres Operations Manager (West), the Primary Care Programme Manager (East and Central), UPCC Admin Manager (East), Senior Practice Manager (Healthy Prestatyn Iach), and information available in the public domain. We would like to express our gratitude to Primary Care colleagues in 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 or accuracy of the information provided.

2. Detailed Audit Findings

Objective 1: There are appropriate pathways in place for patients to access the UPCCs, and these are resourced sufficiently, with capacity fully utilised.

2.1 Over the last two years the Health Board has established Urgent Primary Care Centres (UPCCs) across its three main areas, East, Central, and West, to serve the population of North Wales. Each area developed their UPCC models independently and whilst the purpose and remit are comparable, their operational structures and funding sources are not. The East and West UPCCs are based on Health Board models available to all General Practitioners (GPs) and residents in their respective regions, whilst the Central UPCC has adopted a Cluster based model supporting the North Denbighshire Cluster only. The Wrexham (hub) UPCC commenced 9th December 2020 with the Mold service following on the 11th January 2021. The Central UPCC commenced a year later on 23rd December 2021, whilst the West model was launched on the 30th May 2022.

2.2 The East and Central UPCCs funding was sourced via successful Welsh Government Pathfinder bids. The funding is non-recurring and has been extended from the initial year of inception. We were advised that the bids had been subject to scrutiny and approval by relevant Executive Management Groups, though we did not receive the relevant minutes for review. The West UPCC development is funded recurringly and was subject to a full Board approved business case.

2.3 All regions have established and documented comprehensive patient pathways, referral routes, system guidance notes, and consistent referral criteria to support the management of patient referrals. Patients cannot access UPCC services directly nor does the service offer "walk-in" sessions. The Central UPCC is only available to patients registered with the six GP Practices that comprise the North Denbighshire Cluster GP and is accessed via the GP route. GP reception teams triage patients over the phone and allocate UPCC appointments for patients that meet the UPCC referral criteria directly onto the GP EMIS patient management system. The service provides patients with same day appointments, and the system offers real-time booking based on session availability (currently 16 slots per day) ensuring sessions cannot be overbooked.

2.4 The East and West UPCCs accept referrals from all GP Practices within their respective areas, as well as from Emergency Departments, Minor Injury Units, 111/ Single Integrated Clinical Assessment and Triage Service (SICAT), Lymphoedema (East), and Community Pharmacies (West). Like the Central process, GP patients are triaged by the GP reception teams over the phone and are referred to the UPCC where their condition meet the documented referral criteria. However, the East and West area GP reception teams cannot book UPCC sessions directly. Rather, they are required to complete an online referral form via Sharepoint which is reviewed by the relevant UPCC admin team, before being entered onto the Adastra patient management system. In instances where referrals do not meet the UPCC criteria, the referring GP practices are notified and patient care is transferred back

to the relevant GP surgery. UPCC clinicians triage all referrals over the phone and will seek to resolve patient concerns where possible (e.g. issuing a prescription, or providing advice). Where issues cannot be addressed over the phone, UPCC clinicians arrange a same day face to face appointment with the patient at the UPCC. We were advised that this practice can impact reporting, as a single patient can be allocated two separate sessions – one session for the phone consultation, and one for the face-to-face appointment.

2.5 Whilst similar, there are some differences in how the East and West UPCC manage Emergency Department (ED) referrals. Health Board Emergency Departments utilise the Symphony patient management system. Both East and West UPCC teams review Symphony following triage by ED and refer suitable patients to the UPCC. The East have also implemented "at the door" triage by UPCC Clinicians to capture suitable patients before they access the ED pathway. The UPCC Operations Manager (West) advised that the West UPCC team had introduced a new approach to managing ED referrals during late November 2022 giving UPCC clinicians direct access to Symphony to identify and signpost suitable patients sooner to further reduce the pressure on ED.

2.6 Intended capacity was integral to the UPCC service proposal bids / Business Case, along with finance and staffing resource requirements, and expected benefits. We sought to establish actual capacity levels across the three areas and were advised that the number of available sessions vary depending on resource availability for each day, though monthly aggregates are provided to Welsh Government as part of the UPCC performance reporting cycle. The UPCCs utilise a diverse skill mix which include GP's, Advanced Nurse Practitioners (ANP), physiotherapists, and Advanced Paramedic Practitioner (APP). The Project Manager for the East and Central UPCCs stated that both area UPCCs have faced significant challenges in meeting capacity due to difficulty in appointing to vacant posts and / or low levels of clinical cover. Vacancies can only be offered on a fixed-term basis (due to service funding being non-recurring) which may adversely affect post desirability. The West UPCC Operations Manager stated that they had not been subject to the same challenges and had been able to appoint to vacant posts on a permanent basis. The West UPCC Business Case was for the implementation of UPCCs across two sites (Ysbyty Alltwen and Ysbyty Penrhos Stanley). However, to ensure the service is equitable and accessible to all West patients, the team also established the service at Ysbyty Gwynedd utilising current staffing resources. At the time of review the West team were progressing two UPCC bids: one for additional staffing to ensure that the robustness of the service is maintained across the three sites, and a second bid proposing further expansion of the service to Tywyn.

2.7 The following table provides an overview of UPCC capacity data by area and compares average actual monthly reported capacity to the intended capacity per the UPCC bids / Business Case. The data shows that whilst actual capacity is well-utilised, total capacity is significantly lower than the proposal documentation.

Table 1: Capacity

	East UPCC	Central UPCC	West UPCC
Proposal Bid / Business Case Narrative	96 sessions (equating to 13,440 appointments over 5 months).	We anticipate that providing 600 appointments/month would result in a significant impact for both primary and secondary care.	56 appointments will be available within the UPCCs daily. Service based on 5 day model.
Planned Monthly Capacity based on bids/Business Case.	2688	600	1120
Average Monthly Capacity *(number of appts / slots / consultations available, e.g. F2F/Virtual)*	987	194	490*
Average Capacity utilised *(Total number of consultations - F2F/Virtual)*	734	179	627*
% of Capacity utilised	74%	92%	128%
Average Monthly Capacity as % of Planned Capacity	**37%**	**32%**	**44%***

Data source – UPCC bids (East and Central) / Business Case (West). 2022-23 Welsh Government UUPCC Submissions (Measure 4). Average Capacity calculations based on months where all relevant fields had been completed. Months with partial data were excluded.

** West averages include data for the first (initial) three months of service provision. Capacity has subsequently increased significantly. The average monthly capacity for the last three months was 700, increasing the Average Monthly Capacity as % of Planned Capacity to 63%.*

2.8 The Project Manager for East and Central UPCCs stated that accommodation was also a significant challenge for the East and Central area UPCCs. Issues raised included not enough permanent designated rooms for the service leading to UPCC staff having to look for additional space daily to accommodate first contact physiotherapists (Wrexham Maelor), and instances (though rare) whereby UPCC designated rooms had to be utilised by other services, directly impacting UPCC service provision. We confirmed that proposals were currently ongoing regarding the relocation and development of the Central UPCC. Accommodation was not raised as a concern by the West UPCC team. The following table provides a summary of UPCC background information:

Table 2: UPCC Summary

	East	Central	West
Funding source	Non-recurring funding via Welsh Government pathfinder bid.	Non-recurring funding via Welsh Government pathfinder bid.	Recurring funding following successful Board approved Business Case application.
Model type	Health Board model, covering 39 GP practices Plus ED, MIU, 111/SICAT & Lymphoedema referrals.	Cluster based model covering 6 practices – North Denbighshire Cluster only.	Health Board model, covering 28 GP Practices Plus ED, MIU, 111/SICAT & Community Pharmacy.
Launch date	9/12/20 Wrexham Maelor 11/1/21 Mold MIU	23/12/21	30/5/22
Location	Wrexham Maelor Hospital (hub). Mold MIU (spoke).	Currently Healthy Prestatyn Iach. Advised service will be relocating to Ysbyty Glan Clwyd December 2022.	Ysbyty Alltwen (Porthmadog) Ysbyty Penthos Stanley (Holyhead). Ysbyty Gwynedd (Bangor).
Referral route	Online referrals from GP Practices. Patients streamed from ED, MIU & 111/SICAT. Online referrals from Lymphoedema.	Patients added directly to clinical system in GP practice. UPCC then assess/treat.	Online referrals from GP Practices & Community Pharmacies. Patients streamed from ED, MIU & 111/SICAT.
Services / criteria covered	Telephone consultation. Face to face. Video consultation (where IT allows.	Telephone consultation. Face to face.	Telephone consultation. Face to face. Video consultation (where IT allows.
Systems	Sharepoint Adastra Symphony (ED)	EMIS (GP system)	Sharepoint Adastra Symphony (ED)
Main issues raised	Difficulty appointing Accommodation	Difficulty appointing Long-term sickness absence Accommodation	West UPCC team currently offering service in YG using existing resources – bid in place to staff appropriately.

Data source – Urgent Primary Care Peer Review presentation (Sept 22) and discussions with UPCC Operational Managers.

Conclusion:

2.9 The Health Board has appropriate documented pathways in place for patients to access the UPCCs, however planned service capacity has not been achieved. Reported data shows that whilst actual UPCC capacity is well-utilised, the total capacity across the three areas is significantly lower than the planned capacity

stated in the proposal bids / Business Case. Part of this variance may be attributable to the impact of service recruitment and accommodation challenges. In terms of scope and accessibility, the Central UPCC service model (cluster based) differs significantly from the East and West models (area wide). We have not been privy to the ongoing discussions regarding the development of the Central UPCC service however we urge the Health Board to consider the impact of restricting UPCC access and services offered to select members of the public based on their choice of GP Practice, particularly if the UPCC is to be relocated.

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

Objective 2: Performance data demonstrates the Urgent Primary Care Centres have reduced pressures within Primary Care services and Secondary Care Emergency Department services.

2.10 Each month the three area UPCCs are required to submit performance data to the Welsh Government. The returns are completed using standard templates and show performance against seven measures in accordance with Welsh Government requirements. The following tables present a summary of 2022-23 UPCC referral data by area. Note that the Health Board aggregates will be understated - East and West UPCCs provided December 2022 submissions whilst the data provided by Central UPCC was for September 2022. Table 3 shows the total number of UPCC referrals and consultations by area, whilst Table 4 analyses the data by referral source. The information was extracted directly from the Welsh Government submissions.

Table 3: UPCC referral and consultation data per WG submissions (2022-23)

Area	Reporting Period	Total Referrals from Case Log (unadjusted)	Total Referrals Reported to WG	Consultation (Telephone / Video/Face to Face)	Consultations as % of all contact/referrals received
East UPCC	Apr-Dec 2022	8,545	7,035	5,902	84%
Central UPCC	Apr-Sept 2022	1,100	1,283	1,249	97%
West UPCC	Jun-Dec 2022	4,378	4,376	4,196	96%
TOTALS*	**Apr-Dec 2022**	**14,023**	**12,694**	**11,347**	**89%**

**Excludes Oct–Dec data for Central UPCC – version provided for review was as of September 2022*

Table 4: UPCC referral data by source per WG submissions (2022-23)

Referral source	Total number of UPCC referrals by source			
	East UPCC Apr-Dec 22	Central UPCC Apr-Sept 22	West UPCC Jun-Dec 22	TOTAL
GP Practice	6,328	1,283	4,133	**11,744**

ED	625	0	31	**656**
MIU	63	0	168	**231**
OOH/111	15	0	19	**34**
WAST	1	0	0	**1**
Comm based services	0	0	11	**11**
Other	3	0	0	**3**
TOTAL	**7,035**	**1,283**	**4,362**	**12,680**

Data source – BCUHB UPCC Welsh Government submissions

2.11 Key findings from the above tables:

- Health Board UPCCs received 12,694 referrals / contacts over the period April – December 2022 (excluding October, November, and December data for Central UPCC). These referrals resulted in the UPCCs conducting 11,347 telephone, video, or face to face consultations with patients. The variance between the number of consultations and the number of referrals represents patients that did not attend appointments or answer calls / call-back, patients that did not meet the referral criteria / inappropriate referrals, and patients whereby care was transferred back to GPs.
- The data shows that 93% of UPCC referrals and contacts originate via the GP Practice pathway. Between April and December 2022, Emergency Department (ED) referrals accounted for approximately 5% of the total UPCC referrals, with 625 (95%) of the 656 attributable to the East UPCC (Central UPCC received no referrals / contacts from ED per their service model). Analysis of the East and West ED referral data shows that the East UPCC experienced a significant increase in the number of ED referrals during October 2022 which continued through to the end of December.

Table 5: East and West UPCC ED referrals by month (2022-23)

ED Contacts/ Referrals	Apr22	May22	Jun22	Jul22	Aug22	Sep22	Oct22	Nov22	Dec22	TOTAL	% by area
East	10	11	14	60	37	19	166	148	160	**625**	**95%**
West	0	0	0	11	5	2	0	5	8	**31**	**5%**
TOTAL	**10**	**11**	**14**	**71**	**42**	**21**	**166**	**153**	**168**	**656**	**100%**

Data source – BCUHB UPCC Welsh Government submissions

- Releasing capacity within GP Practices and Emergency Departments were among the primary purported benefits of establishing the UPCCs. The impact

on GP Practices can be observed and measured with the reported referral and consultation data, however it is difficult to quantify the full impact on Emergency Departments. Whilst ED referral data is collated and reported, the true impact on ED will include a proportion of patients that were referred to the UPCCs via their GP Practices. In the absence of UPCCs, patients that were unable to secure a GP appointment may have accessed ED directly – the referral data does not reflect this. During early 2022 the East and Central UPCC teams conducted a Patient Satisfaction Survey exercise to obtain patient feedback and asked patients where they would have gone for advice / treatment if the UPCC service was not available, and their GPs had no appointments. The following table shows the responses received. Whilst the responses provide valuable insight it is difficult to determine with confidence the extent that the results can be used to make inferences about the larger population given the sample sizes of 50 and 25 patients respectively.

Table 6: East and Central Patient Satisfaction Survey results (Question 8)

	Community Pharmacy	MIU	ED	111	OOH	Own practice next day	Self-care	No response
East*	8	3	7	7	12	8	11	4
As %	13%	5%	12%	12%	20%	13%	18%	7%
Central	6	0	5	1	1	11	1	0
As %	24%	0%	20%	4%	4%	44%	4%	0%

Data source – BCU UPCC Patient Satisfaction Survey

** Some participants selected multiple answers.*

2.12 Each UPCC team maintain a spreadsheet of case log data to record all referrals and contacts received. The data is taken directly from the patient management systems and is used to inform the Welsh Government performance report submissions (using pivot tables to interrogate the data). We reviewed the relevant case logs and backing documents but were unable to reconcile these to the data reported in the Welsh Government submissions. We were advised that the data is subject to manual adjustments to ensure accuracy and conformance with Welsh Government reporting requirements. However, there is no reconciliation or audit trail of the adjustments made in the backing documents resulting in a lack of transparency. We also found examples of inconsistent data within the backing documents and the Welsh Government Submissions.

2.13 The case log data also shows the number of patients referred by each GP Practice per month. As expected UPCC utilisation varies from practice to practice and is influenced by factors such as practice capacity, resource availability, proximity to nearest UPCC, and reluctance to refer. We were advised that the UPCC teams continually promote the use of the service, which has seen increased utilisation

over time, however there remain some GP practices that have not used the service. The availability of utilisation data provides opportunity for targeted promotion.

Conclusion:

2.14 The Health Board has robust arrangements in place to capture and report UPCC performance data, though reconciliation documents should be incorporated into working documents to ensure transparency. Whilst there are no formal benefit realisation strategies in place directly evaluating UPCC performance data against the original service bids / Business Case, performance is actively monitored and reported to the Health Board and Welsh Government. Furthermore, the impact of UPCCs can be measured with the available performance data.

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

Objective 3: There is oversight of the UPCC service within the Health Board to ensure a quality service is being provided, including a review of capacity, performance data and quality measures.

2.15 We found that each area had established UPCC Governance Frameworks that included embedded copies of key UPCC procedural documents and guidance notes. Additionally, the East UPCC had also developed and implemented a Communication Strategy. We reviewed the documents and noted the following:

- The West UPCC governance framework was created July 2022 and is to be reviewed April 2023.
- The East framework was due for review July 2022 but was replaced in late 2022 by the UPCC East Overview Plan. We were advised that the Overview Plan had been reviewed and approved locally however had not been subject to wider Health Board scrutiny or approval.
- The Central UPCC governance framework was incomplete and in draft stage. Again, we were advised that work had been progressing however had been put on hold pending the outcome of the proposed changes to the Central UPCC service provision.
- We found that the Governance Frameworks were consistent in terms of format and content across the three areas, though a new format had been used for the East Overview Plan. Each framework (and the new Overview Plan) included links to best practice and guidelines and embedded copies of all relevant UPCC documents including UPCC staff roles duties and responsibilities, inclusion / referral criteria, referral forms, user guides, risk assessments, data security and confidentiality agreement forms, clinical room requirements, and feedback questionnaires.
- The East UPCC communication strategy was overdue for review – the version provided was dated February 2021.
- As alluded to in paragraph 2.10, the East and Central UPCC teams conducted a Patient Satisfaction Survey exercise during March 2022 to collect gather

patient feedback and support UPCC development.

2.16 The Health Board has robust oversight arrangements in place to support UPCCs. UPCC performance data is reported to Welsh Government monthly and the UPCC Operational Managers provide the performance data and regular service updates to Health Board Directors and cluster leads (though minutes are not recorded for operational meetings). We found that UPCC performance, developments, and issues of significance had been consistently reported at senior Health Board executive meetings and Committees. We reviewed copies of agendas and minutes for the last four held meetings / committees and confirmed that UPCC was reported at the Health Board Meeting, Quality Safety and Experience Committee (QSE), Performance Finance and Information Governance Committee (PFIG), and Partnerships People and Population Health Committee (PPPH). UPCC information and data had been included in the following Health Board papers and reports:

- 2022/23 Board Assurance Framework.
- Annual Plan Monitoring Report 2022-23.
- Annual Report and Accounts 2021-22.
- Health Board Winter and Resilience Plan 2022-23 (Draft).
- Clinical Services Strategy Update.
- Community Health Council and Health Board Board to Board – 20.10.22 - Winter Plan Update.
- Corporate Risk Register Report.
- Finance Reports.
- Living Healthier, Staying Well strategy refresh.
- Operational Plan Monitoring Report (OPMR) 2022-23.
- Partnerships, Engagement and Communication Update.
- Primary Care Update.
- Quality Achievements Report.
- Quality and Performance Report.
- Unscheduled Care and Winter Plan Update.
- Unscheduled Care Update.
- YGC Improvement Plan.

2.17 Despite inclusion in the above papers and reports, we found no evidence of UPCC scrutiny in the published minutes, nor did we find any examples of UPCC specific questions, issues, or concerns raised by the respective Board or Committee members. There were no specific UPCC update papers or progress reports presented for scrutiny or requested in the sample period reviewed.

Conclusion:

2.18 We confirmed that the Health Board has robust oversight arrangements in place to support UPCCs. Whilst we found no evidence of Board or Committee scrutiny in the published minutes, UPCC performance data and issues of significance are included within key Health Board papers / reports and remain visible at senior Health Board forums. The UPCC developed Governance Frameworks and Communication Strategy whilst robust should be periodically reviewed to ensure continued relevance and alignment with the Health Board Governance Framework.

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

Appendix A: Management Action Plan

Matter Arising 1: UPCC models (Design)			**Impact**
The variation in the models used for the UPCCs within the Health Board raise a number of issues: • The use of the cluster based model in the Central area limits the access and services offered to members of the public, based on their choice of GP Practice. • The non-recurrent funding model for East and Central areas has resulted in difficulty recruiting staff, and limits the service that can be provided to patients. • East and Central areas have issues with lack of accommodation, which impacts the ability to provide consistent service to GPs and patients.			Potential risk of: • Limited access to the service for patients. • Inability to provide a consistent service to patients.
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	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***	Q4 2023/24	Director of Primary Care / Deputy Executive Medical Director

Matter Arising 2: Benefits realisation (Design)			**Impact**
Actual UPCC capacity is significantly lower than the projected capacity stated in the development bids / Business Case. Releasing capacity within GP Practices and Emergency Departments were among the primary purported benefits of establishing the UPCCs, however there is no formal Benefit Realisation Strategy in place to monitor delivery of expected benefits. There has been no formal evaluation of UPCC performance data against the original service bids / Business Case.			Potential risk of: • Limited capacity impacting service provision. • Stated benefits of the services are not realised.
Recommendations			**Priority**
2.1	Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits.		**High**
2.2	The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated.		
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	Q3 2023/24	Acting Associate Director, Primary Care
2.2	Business case guidance to require clear measures linked to identified benefits.	TBA by Exec	Executive Director of Planning & Transformation and Executive Director of Finance
	East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases	April 2023	Primary Care Planning & Commissioning Manager

Matter Arising 3: Data Reconciliation (Operation)			**Impact**
Each UPCC retain a case log of all referrals and utilise the data to inform their monthly Welsh Government performance report submissions. We reviewed the relevant backing documents for the December 2022 (East and West UPCC) and September 2022 (Central UPCC) submissions and found the following limitations and opportunities: • We were unable to reconcile source data directly to the data submitted to Welsh Government - adjustments are not documented. • For December 2022, the West UPCC referral data was not clearly reported in Measure 1. Additional fields were used which made it difficult to determine the actual referral numbers, and reconciliation totals included within the Welsh Government report did not balance between Measures. We also found examples of inconsistencies in the backing document (UPCC REFERRALS CHECK – MASTER doc) whereby referral aggregates varied between worksheets. • GP Practice referral data and UPCC utilisation is captured and tracked over time.			Potential risk of: • Lack of transparency. • Inconsistent or inaccurate reporting. • UPCC underutilised.
Recommendations			**Priority**
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.		**Medium**
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.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Review of reconciliation data for West and inaccuracies corrected	01/03/2023	Operations Manager - Urgent Primary Care Centres (West)

	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***	31/03/2023	Deputy Associate Director of Primary and Community Care (Centre)
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 31/05/2023	Operations Manager - Urgent Primary Care Centres (West) / Deputy Associate Director of Primary and Community Care (Centre)/ Primary Care Programme Manager (East) Operations Manager - Urgent Primary Care Centres (West) Associate Director of Primary Care

Matter Arising 4: Governance Frameworks and Communication Strategies (Operation)			**Impact**
We found that each area had established UPCC Governance Frameworks that included embedded copies of key UPCC procedural documents and guidance notes. Additionally, the East UPCC had also developed and implemented a Communication Strategy. We reviewed the documents and noted the following: • The Central UPCC Governance Framework was incomplete and overdue for review. • During late 2022 the East UPCC replaced their Governance Framework with an Overview Plan – the content was comparable to the previous Governance Framework. We were advised that the Plan had not been subject to wider approval. • Central and West UPCCs have not established Communication Strategies. The East Communication Strategy was overdue for review.			Potential risk of: • Governance arrangements outdated. • Supporting documents no longer relevant. • Lack of ownership and accountability.
Recommendations			**Priority**
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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Communication strategy to be drafted and reviewed in line with UPCC objectives	30/04/2023	Operations Manager - Urgent Primary Care Centres (West) / Deputy Associate Director of Primary and Community Care (Centre) / Primary Care Programme Manager (East)

	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***	31/05/2023 31/03/2023	Operations Manager - Urgent Primary Care Centres (West) Deputy Associate Director of Primary and Community Care (Centre)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

Teitl adroddiad: ***Report title:***	Internal Audit Recommendations
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	15 May 2023
Crynodeb Gweithredol: ***Executive Summary:***	An important role for the Audit Committee is to monitor the implementation of agreed internal audit recommendations. With a new Chair of Audit leading the way, we have made a number of changes to refresh and improve the way that recommendations will be managed. The most fundamental shift is a separation of the internal audit recommendations and the external audit recommendations. These will be taken as two separate papers on the agenda. The audit recommendations are also currently managed in a system provided by internal audit. This will also change and will be held, managed and shared by the Board Secretary, giving greater accountability and control to ensure the highest standards are maintained. The Board Secretary will support the Audit Chair by ensuring that all actions are updated prior to Committee and will present two items for assurance at each meeting. They are: • a highlight summary in terms of progress made with the recommendations from internal and external audits • a focus on high risk recommendations that exceed their original implementation date It is important to note that the paper attached for this meeting is the new format and structure of the report and offers the separation. However, the actions need to be reviewed and updated and the office of the Board Secretary have yet to do this. As such some overdue items may actually have been completed and some additional ones may have become overdue. With a change of personnel in some roles, a thorough review will be undertaken for assurance by the Board Secretary. The Board Secretary will complete this outside of the meting and share with the Audit Committee, rather than waiting for the next formal meeting. Reporting will then continue as described with the updated recommendations presented to committee; Through consultation with the Audit Chair, action leads will be invited to Audit Committee and held to account for the timely progress of their actions, particularly where the Committee is not assured. Board Secretary to undertake sampling of closed recommendations to provide a level of assurance to the Committee.
Argymhellion: ***Recommendations:***	The Committee is asked;

	• To take assurance from the new way to manage the recommendations and to receive the updated audit recommendations under separate cover.			
Arweinydd Gweithredol: ***Executive Lead:***	Interim Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Marty McAuley, Deputy Director of Governance, Deputy Board Secretary			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
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: ***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:***				
There is a system and Process in place that is effective but is not effeicient, The Chair of the Audity Committee has requeted some changes such as the seperation of registers and the Office of teh Board Secretary have more changes to make. Once the recdommendations have had thei rupdate this month, the Audit Commitee would be able to take a much higher level of assurance.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with Internal Audit requirements.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	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 (there are no associated impacts on any of the protected groups).			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	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 (the report does not relate to a decision, strategic or otherwise).			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews / recommendations
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** A thorough review and update of all actions for assurance to be completed by the Board Secretary and shared with the Audit Committee.	
Rhestr o Atodiadau: ***List of Appendices:***	

Internal Audit Summary

Internal Audit: Name of Audit/Project	Year Ref	No. of Recommendations proposed for closure this time	Total No. of Outstanding Recommendations	No. outstanding which exceed their original implementation date		
				Low	Med	High
Audit Wales CHC Follow-up	22/23	0	3	0	0	0
Audit Wales Follow-up – Counter Fraud	22/23	2	3	1	2	0
Board and Committee Reporting	22/23	0	4	0	0	4
Budgetary Control & Financial Reporting, including COVID-19 financial governance	21/22	2	2	1	1	0
Business Continuity Plans	21/22	1	0	0	0	0
Chair's Action	22/23	0	4	0	3	1
Charitable Funds	22/23	0	7	0	0	4
Clinical Audit	21/22	3	4	0	1	3
Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	22/23	0	2	0	0	1
Cyber Security	19/20	1	1	0	1	0
Delivery of Health Board Savings	22/23	0	4	0	0	1
Digital Strategy	22/23	0	1	0	0	0
Effective Governance: YG	22/23	5	1	0	0	1
Effective Governance: YWM	22/23	3	3	0	0	1
Employment of Medical Locum Doctors	21/22	1	2	0	1	1
Establishment control – Leaver management	21/22	2	2	0	1	1
Impact Assessments	21/22	1	1	0	1	0
Infection Prevention and Control - Safe, clean care	18/19	1	0	0	0	0
Integrated Service Boards	21/22	0	1	0	0	1

Internal Audit: Name of Audit/Project	Year Ref	No. of Recommendations proposed for closure this time	Total No. of Outstanding Recommendations	No. outstanding which exceed their original implementation date		
				Low	Med	High
Learning lessons	21/22	1	0	0	0	0
Management of Utilities	22/23	0	1	0	0	0
Network and Information Systems Regulations 2018 (NIS Regulations)	21/22	2	1	1	0	0
On-Call Arrangements	21/22	0	4	0	0	4
Procurement & Tendering	21/22	0	1	0	1	0
Performance measure reporting to the Board – Accuracy of information	20/21	0	2	0	2	0
Quality Improvement Strategy	19/20	0	1	0	0	1
Risk Management	20/21	1	1	0	1	0
Roster Management	22/23	3	3	0	1	2
Speak out Safely	22/23	2	1	0	1	0
Standards of Business Conduct: Declarations	21/22	1	4	0	1	3
Waste Management	21/22	1	1	0	1	0
Welsh IG toolkit	22/23	1	1	0	1	0
Women’s Service - Sustainability of Services	21/22	0	2	0	1	1
Total		**34**	**68**	**3**	**21**	**30**

*No. of Recommendations proposed for closure includes ‘Final Client Approved’ (Executive sign off) and ‘Partial Client Approved’ (marked as implemented by Recommendation Owner). Where the Rec is only Partial Client Approved, it is still counted as overdue in the ‘Number outstanding which exceed their original implementation date’ columns as it has not received final Executive approval.

Appendix 2: Internal and External Audit Recommendations - High Risk and Overdue

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
64	BCU-1920-35	Quality Improvement Strategy	Started	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.	High	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	11	30/09/2023	Following appointment of the new executive lead for quality and the new statutory duty of quality coming into effect on 01 April 2023, the deadline has been refreshed to ensure all key and new stakeholders have a full opportunity to engage and shape the development.	Matthew Joyes,Assistant Director Of Patient Safety And Experience	Gill Harris,Executive Director Nursing And Midwifery
121	BCU-2122-06	Standards of Business Conduct: Declarations	Started	Declarations of Interest Compliance	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.	High	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. 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 1st of April 2022. This will also	30/06/2022	2	31/12/2022	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. It is anticipated that roll out will be completed by the end of December 2022. Delays in implementation have been the result of an extended process in signing off the DPIA as well as resource constraints within the OBS..	David Seabrooke,Interim Assistant Director of Governance	Molly Marcu,Interim Deputy Board Secretary

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
							be supported by a communications plan and a refreshed FAQ page 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.						
122	BCU-2122-06	Standards of Business Conduct: Declarations	Started	Declarations of Interest System	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.	High	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,	30/06/2022	2	31/12/2022	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. It is anticipated that roll out will be completed by the end of December 2022. Delays in implementation have been the result of an extended process in signing off the DPIA as well as resource	David Seabrooke,Interim Assistant Director of Governance	Molly Marcu,Interim Deputy Board Secretary

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
							and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late.				constraints within the OBS.		
124	BCU-2122-06	Standards of Business Conduct: Declarations	Started	Monitoring and Reporting arrangements	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.	High	5.1 DOI monitoring will take place monthly with scope incorporating: The completeness of the disclosures for decision makers. Quality assurance checks on submissions. Significantly out of date disclosures requiring escalation. Monthly update of ESR starters and leavers data. DOI disclosures requiring follow-up action. Gifts and hospitality declaration monitoring. 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. The annual report on gifts and hospitality will be submitted to the Audit Committee in order	31/05/2022	2	31/12/2022	Compliance monitoring continues on a monthly basis with focus on high risk areas such as the board member declarations, which were previously highlighted in the Annual External Audit of the financial statements. This process will be automated on the MES Declare system	David Seabrooke,Interim Assistant Director of Governance	Molly Marcu,Interim Deputy Board Secretary

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							to evidence compliance.						
125	BCU-2122-07	Integrated Service Boards (ISB)	Started	ISB Governance Arrangements	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.	High	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	3	30/11/2022	The revised Scheme of Delegation, together with the Risk Management Policy have been completed and were presented for sign off to the June Audit Committee. The revised Governance and Accountability Framework will be presented to the November Audit Committee.	David Seabrooke,Interim Assistant Director of Governance	Gill Harris,Executive Director Nursing And Midwifery

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
135	BCU-2122-13	Clinical Audit	Implemented - Partial Client Approved	Progress against the Clinical Audit Plan is reviewed regularly by an appropriate forum	Regular quarterly reports are to be presented to the QSE, highlighting progress against the plan. 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. The overarching CEG should receive regular reports from local CEGs as per the cycle of business.	High	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. 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). and 3.3 The Cycle of Business will be strengthened for both Clinical Effectiveness Group and Quality, Safety and Experience Committee to be explicit about the reports delivered. Quarter 2 and 3 reports will be included in updated cycle of business / recognising the 10th February Clinical Effectiveness	31/05/2022	6		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	Joanne Shillingford,Area Manager	Nick Lyons,Executive Medical Director

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							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.						

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136	BCU-2122-13	Clinical Audit	Implemented - Partial Client Approved	Results of clinical audits are fed back to the appropriate clinical forums, management groups and committees.	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 CEGs and the West Quality, Safety and Clinical Effectiveness Group Meeting. Compliance on Tier 1 audits should be reported by site within the Health Board to ensure that the methodology used does not provide false assurance on compliance. Feedback and lessons learned from audits should be included within reporting to Groups and Committees to provide assurance to the Health Board and ensure communication across sites / divisions .	High	Management Comment National timescales stood down at height of COVID and reports were no longer required for submitting to Welsh Government. In 2021 / February 2022 we have additionally had clear direction from organisation to prioritise front line service delivery and step down non-essential activity. Audit was one of these areas which was paused or reduced as part of this. The underlying reason for non-compliance (as reflected on our risk register) within responses from Clinical Leads was identified as insufficient capacity within the corporate team and localities (this deficit was exaggerated by COVID) but some capacity deficit predated it. The Clinical Effectiveness business case was submitted to address the underlying cause. The business case has been given priority 2 within the Integrated Medium Term Plan (IMTP) process, at the moment, there are discussions for the next date to	31/10/2022	4		The pro-forma 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.	Joanne Shillingford,Area Manager	Nick Lyons,Executive Medical Director

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							resubmit for next year, but nothing has been finalised yet. The AMaT license has been renewed for two years accounted for within 2021/2022 financial year with savings made for extended the license for two years. This will enable funding allocated against AMaT in 2022/2023 and 2023/2024 financial years to support funding of temporary staff. Structured assessment will take place over the next two years to clearly quantify the benefits realisation of AMaT, which will inform the decision to renew the license which is due for renewal 1st April 2024. Also with regard to the reference above to site scores and compliance, just to confirm the level the data is reported at is determined by the host of the national audit and not by all those that report data for BCUHB at a site level. Agreed Actions. 4.1a Using temporary/fixed term staff to support the team initially, also finalise discussions with Quality department and consider						

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							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 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. 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. Revisit locality reporting,					

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
							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. Fully implement clinical review of audit results (as per drafted process developed Februar y 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.						

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							Secure capacity identified within business case (delivering a hub and spoke model to increase capacity within central team aligned to locality. 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. Ensure continuation of current health check meetings to develop and maintain division visibility of audit activity and risks, and to promote engagement and accountability.						

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137	BCU-2122-13	Clinical Audit	Implemented - Partial Client Approved	Arrangements in place for Tier 3 audits	Reasons why Tier 3 audits are required should be reviewed to ensure here is justification in at least one of the two sections that require a reason. The uploading of an assessment for each audit would further strengthen the reason/justification for undertaking the audit. 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. Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions / localities are responsible for Tier 3 audits, we would suggest the learning / feedback is provided to the Clinical Effectiveness Team and a process put in place to ensure this learning / feedback is shared across the Health Board.	High	A 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. 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. a) Rollout of AMaT for Tier 1 and Tier 2 and NICE guidance will take place in the first instance and dependant on the implementation of the software across BCUHB, Tier 3 will be rolled out at a later date. This will include capturing outcomes from audits. b) By developing the Tier 3 self-registration further to	31/12/2022	1		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	Joanne Shillingford,Area Manager	Nick Lyons,Executive Medical Director

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							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.						

ID	Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp Date	NO. of Revisions	Revised Imp Date	Last Status Update	Owner	Final Approver
153	BCU-2122-21	Women's Services Division – Sustainability of services	Started	Finance and Contracting Arrangements	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.	High	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 Contracting Team and a formal action plan requested for resolution. Activity data will continue to be validated for responsible	31/12/2021	0	30/05/23	A paper was presented to HBLT on 7/12/22 noting the Women's Services' ongoing concerns regarding the lack of assurances and timely clinical data being received by the Countess. This element provided background to the overall paper (item HBLT22.85) drafted in response to the Countess' communication requesting the Health Board to maintain its current maternity activities, a firm revenue commitment for their Capital Business case for a new Maternity Unit. The Health Board has responded to the Trust and confirmed our intention to repatriate the current activity to ensure sustainability of local maternity services. In response, the Trust has requested our activity trajectories for the proposed repatriation, which also includes Gynaecology, Neonatal and Children's Services /activity currently commissioned by the Countess. The Health Board	Fiona Giraud,Director Of Midwifery & Womens Services	Gill Harris,Executive Director Nursing And Midwifery

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							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 &				Finance and Contracting teams are co-ordinating this exercise with support from Services.		

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							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.						
155	BCU-2122-22	Employment of Medical Locum Doctors	Implemented - Partial Client Approved	New Recommendation	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.	High	Tripartite Contract Management meetings to be arranged on a monthly basis. Tripartite Senior Contract Management meetings to be held quarterly.	30/06/2022	2		Implementation date extended 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	Nick Graham,Workforce Optimisation Advisor	Jason Brannan,Deputy Director of People

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											rectify them as part of the contract management oversight.		
157	BCU-2122-23	Roster management	Implemented - Partial Client Approved	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.	High	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	1		Communication to all agencies has been issued. Communication to all Nursing Managers has been issued Training sessions have been put on for nursing teams on 2 separate occasions but have been poorly attended to date, this poor attendance has been flagged with AD for Nursing Workforce and further sessions are being arranged for September 22 with attendance now being made mandatory. All original actions and further actions have now been completed	Nick Graham,Workforce Optimisation Advisor	Jason Brannan,Deputy Director of People
158	BCU-2122-23	Roster management	Implemented - Partial Client Approved	Implementation of 1 hour breaks	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	High	(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	31/08/2022	1		This is currently being worked on by the temp staffing team but is delayed due to pressures of the off framework agency issues they are currently dealing with. All actions have been implemented as per the action plan.	Nick Graham,Workforce Optimisation Advisor	Jason Brannan,Deputy Director of People

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					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.		& Culture Executive Delivery Group and implemented						
160	BCU-2122-24	Establishment control – Leaver management	Implemented - Partial Client Approved	Operational management compliance	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.	High	The Workforce Performance & 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	31/01/2022			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.	Nick Graham,Workforce Optimisation Advisor	Jason Brannan,Deputy Director of People

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							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						

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							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.						
164	BCU-2122-26	On-Call arrangements	Pending	Review of on-call arrangements	1.1a 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. 1.1b Management should consider the feedback from our questionnaire when reviewing on-call arrangements,	High	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. 1.1b Proposals will be presented to the Executive Team, for approval.	12/10/2022				Phil Orwin,Interim Director of Regional Delivery	Gill Harris,Executive Director Nursing And Midwifery

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					and how these can be addressed. 1.1c 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.								
165	BCU-2122-26	On-Call arrangements	Pending	Rota guidance / sustainability	The following should be documented for on-call rota's: Minimum staff numbers Seniority / experience mix Timelines for preparation and issuing of rotas Frequency and type of each 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	High	2.1 On-call document, covering the recommendations above will be issued to all staff.	01/07/2022	1	13/01/2023	The definitive rota and implementation has been delayed due to the delay in implementation of the operating model. This was flagged as a potential risk when the audit response was given. The revised timescale is January 2023 to Execs / HBLT for agreement	Phil Orwin,Interim Director of Regional Delivery	Gill Harris,Executive Director Nursing And Midwifery

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					to determine if they can be put back on it								
166	BCU-2122-26	On-Call arrangements	Pending	Compensatory rest and payment	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.	High	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.	11/07/2022	0		The compensatory rest policy is in the process of being confirmed, as there are many local differentiations in arrangements, and HR is reviewing the compensatory payments when we understand the intensity of the rotas, as under Agenda for Change, that drives the payment.	Phil Orwin,Interim Director of Regional Delivery	Gill Harris,Executive Director Nursing And Midwifery
167	BCU-2122-26	On-Call arrangements	Pending	Training	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	High	4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey. 4.1b Manual to be developed with key	12/12/2022				Phil Orwin,Interim Director of Regional Delivery	Gill Harris,Executive Director Nursing And Midwifery

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					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.		information, and details for those on call. 4.1c All staff to receive training with a programme and timescale set for refresher training every two years. 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.						
176	BCU-2223-04	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	Started	Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43)	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	High	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	31/12/2022	2	30/06/2023	While some of this work is now complete, continued high demand on the Health Board's small Digital Communications Team and the lengthy recruitment process will mean we need to revise the current timeline for completing these actions. 1.1 Continued high demand on the Digital Communications Team has delayed the new policy being finalised. .1.2 Review of current administration access has been completed and training/support will continue as required. The process of	Andrew Rogers,Head Of Corporate Communications	Teresa Owen,Executive Director Of Public Health

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					the English website.		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.				commissioning external support to review the website is almost complete. While we now expect this to be competed later than planned, the cost (£15,000) of commissioning this support has meant we cannot get the level of support we initially indicated so we expect it to be completed in a shorter period of time. We expect the advert for a dedicated translator to go live in the first week of January. The recruitment process has meant it has taken longer to complete this action than expected. All devolved editors have been contacted and reminded about the translation and publication requirements for the website and offered refresher training sessions.1.3Update on the recruitment of a dedicated translator provided above. Regular audits of the website are now being carried out.		

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179	BCU-2223-05a	Effective Governance: YWM	Pending	Clinical Audit	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	High	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 EIHC Medical Director will enable, as part of the wider team, a robust, structured approach to developing and delivering the action plans.	23/11/2022	0		This is not my action, this sits with Director of Nursing and Medical Director	Emma Jane Hosking,Hospital Site Medical Director / Consultant Anaesthetist	Gill Harris,Executive Director Nursing And Midwifery

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184	BCU-2223-05b	Effective Governance: YG	Started	Clinical audit	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. 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. Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan.	High	A full list of Tier 3 audits will be Shared via the next Quality Safety & Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focussed and do not duplicate effort. 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. 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	2	31/03/2023	Agenda item at the next IHC West Directors meeting Jan 2023 A full list of Audits will be shared with QSCE Ysbyty Gwynedd January meeting 2023 (December meeting stood down, exception only) Lessons learnt from T3 audits will be a discussion point in the January 2023 QSCE meeting All staff will be encouraged to participate and feedback on T2 audits, Directors will agenda a discussion around this and explore defined ringfenced time to complete / admin to hold	Janw Hughes-Evans,Interim Area Nurse Director West	Gill Harris,Executive Director Nursing And Midwifery

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189	BCU-2223-10	Board and committee reporting	Pending	Request and submission of papers and reports.	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.	High	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				Molly Marcu,Interim Deputy Board Secretary	Gill Harris,Executive Director Nursing And Midwifery
191	BCU-2223-10	Board and committee reporting	Pending	Reporting Breaches.	Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.	High	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				Philippa Peake-Jones,Head of Corporate Office	Molly Marcu,Interim Deputy Board Secretary

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193	BCU-2223-11	Chairs action	Pending	Process Design	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 IM's 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.	High	1.1 The template will be amended as suggested to include the five additional fields. 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 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				Molly Marcu,Interim Deputy Board Secretary	Gill Harris,Executive Director Nursing And Midwifery

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199	BCU-2223-14	Charitable Funds	Pending	Information provided to the board	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.	High	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	31/01/2023				Kirsty Thomson,Head Of Fundraising : Awyr Las	Steve Webster,Interim Executive Director of Finance

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							frequency of information provided to Trustees will be tabled at the Charitable Funds Committee for discussion and reviewed at the Trustee meeting.						
200	BCU-2223-14	Charitable Funds	Pending	Charitable Funds Committee	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	High	.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	31/01/2023				Molly Marcu,Interim Deputy Board Secretary	Steve Webster,Interim Executive Director of Finance

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					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.		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						
201	BCU-2223-14	Charitable Funds	Pending	Strategy	The Charity Strategy should be presented to Board of Trustees for review and approval.	High	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				Kirsty Thomson,Head Of Fundraising : Awyr Las	Steve Webster,Interim Executive Director of Finance
205	BCU-2223-14	Charitable Funds	Pending	charity objectives	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.	High	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				Kirsty Thomson,Head Of Fundraising : Awyr Las	Steve Webster,Interim Executive Director of Finance

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207	BCU-2223-15	Delivery of HB Savings	Pending	Voluntary Early Release (VERS) recurring savings	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.	High	Agreed.	28/02/2023				Rob Nolan,Finance Director - Commissioning & Strategy	Steve Webster,Interim Executive Director of Finance

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 27 September 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with the Corporate Risk Register. This register was reviewed and approved at the Risk Management Group (RMG) on 5 May 2023. The level of risk that this report focuses on is known as Tier 1 risks. These are the risks that score 15 – 25 and are overseen by sub committees of the Board where Members are asked to take assurance from the information provided.			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to take assurance from the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Marty McAuley - Deputy Director of Governance /Deputy Board Secretary			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
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: ***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:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	See the individual risks for details of the related links to Strategic Objectives.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	See the individual risks for details.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group meets monthly and they have helped form and shape the risk register with executive oversight.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: ***Next Steps:*** The eight emerging risks to be fully populated and managed in the risk register. There are further opportunities to strengthen the reporting of assurance across the committee risk reporting.	
Rhestr o Atodiadau: ***List of Appendices:*** .	

Audit Committee: Corporate Risk Register Report

Introduction/Background

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making.

The Corporate Risk Register (CRR) reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

Full risk Profile by Owner

The risks on the risk register which is divided into three tiers.

Tier	Risk Score	Number of Risks
Tier 1	15/16/20/25	48
Tier 2	9/10/12	335
Tier 3	1/2/3/4/5/6/8	212

These risks are each led by an executive director and the accountability for where these risks sit is in the table below.

Board Secretary	4	Chief Operating Officer	7
Chief Digital and Information Officer	1	Deputy Chief Executive	4
Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	15	Director of Primary and Community Care	65
Director of Mental Health and Learning Disabilities	16	Executive Director of Finance	40
Executive Director of Nursing and Midwifery	98	Executive Director of Public Health	30
Executive Director of Planning and Performance	15	Executive Director of Therapies & Healthcare Sciences	80
Executive Director of Workforce and Organisational Development	14	Executive Medical Director	91
Executive Director Transformation, Strategic Planning, And Commissioning	7	Not yet assigned Executive Leadership	98

Tier 1 risks

This risk report will focus on the Tier 1 risks which are those risks that score 15,16, 20 or 25. These are the risks that make up the Corporate Risk Register and are overseen by sub committees of the Board for assurance. These are the highest scoring risks and the ones where the Audit Committee should be assured on how they are being managed. There should also be a read across to the Board Assurance Framework, the purpose of which is to identify and manage risks that could fundamentally stop the organisation from delivering its objectives.

Whilst there are 48 risks in Tier 1, eight of these are emerging risks where it is important to sight the committee on them, but we may not have fully created the risk, its scoring, controls and assurances.

Tier 1 risks by Executive Leadership:

Executive Director of Finance	9	Chief Operating Officer	4
Chief Digital and Information Officer	5	Executive Director of Public Health	3
Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	5	Executive Director of Therapies & Healthcare Sciences	1
Director of Mental Health and Learning Disabilities	2	Executive Medical Director	2
Executive Director of Nursing and Midwifery	5	Executive Director Transformation, Strategic Planning, And Commissioning	2
Executive Director of Workforce and Organisational Development	2		

Tier 1 risks by Board Sub-Committee Leadership:

Quality, Safety and Experience Committee	26 risks
Partnerships, People and Population Health Partnership	9 risks
Mental Health and Capacity Compliance Committee	1 risk
Performance, Finance and Information Governance Committee	4 risks

Tier 1 risks risk score:

Risk score of 15	10
Risk score of 16	21
Risk score of 20	9
Risk score of 25	0

Current risks with a score of 20

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	20
CRR22-20	Residents in North Wales are unable to achieve a healthy weight due to the obesogenic environment in North Wales	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR22-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR23-44	Pathology Laboratory Information Management System (LINC)	Executive Director of Therapies & Healthcare Sciences	Quality, Safety and Experience Committee	20
CRR23-45	Risk to patient and staff safety due to Industrial Action	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	20
CRR23-49	Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	20
CRR23-52	WG cash funding for 2023/24	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	20

Current risks with a score of 16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR22-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR22-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16
CRR22-32 (Formally CRR20-06)	Retention and Storage of Patient Records	Chief Digital and Information Officer	Partnerships, People and Population Health	16

CRR23-33 (Formally CRR20-06)	Risk of Lack of access to clinical and other patient data	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-35	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.	Executive Director of Finance	Quality, Safety and Experience	16
CRR23-40	Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience Committee	16
CRR23-41	The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience Committee	16
CRR23-42	Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT)	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	Quality, Safety and Experience Committee	16
CRR23-43	Risk of Irreversible Sight-Loss from Delayed Care for “New” and “Follow-Up” Glaucoma Patients	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	Quality, Safety and Experience Committee	16
CRR23-51	Risk of failure to achieve the initial financial plan for 2023/24 (£134.2m deficit), because of failure to achieve the level of financial improvement included in the plan	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	16
CRR23-53	Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-54	Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-55	Inability to manage ambulance demand in a safe timely fashion.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-56	Inability to deliver safe timely care in Emergency Units.	Chief Operating Officer	Quality, Safety and Experience Committee	16

Current risks with a Score of 15

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR22-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15
CRR23-34	There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	Executive Director of Public Health	Partnerships, People and Population Health	15
CRR23-46	Duplicate Hospital Numbers	Chief Digital and Information Officer	Partnerships, People and Population Health	15
CRR23-47	There is a risk to the safety of inpatients within MHLD identifed by the Health and Safety Executive in their Notice of Contravention under Section 28(8) of the Health and Safety at Work Act 1974.	Director of Mental Health	Quality, Safety and Experience Committee	15
CRR23-48	There is a risk to patient safety within MHLD inpatient units presented by access to low height and other ligature anchor points	Director of Mental Health and Learning Disabilities	Quality, Safety and Experience Committee	15
CRR23-50	Financial outturn for 2022/23	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	15

Removed from the corporate risk register

CRR20-05	Timely access to care homes – Risk entry closed and replaced by CRR23-40 and CRR23-41
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients – Risk entry closed and desegregated into individual clinical conditions, replaced by Tier 1 risks CRR23-42 and CRR23-43
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2
CRR21-12	National Infrastructure and Products De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce. De-escalated, risk being managed at Tier 2 Awaiting Confirmation of De-escalation at Quality, Safety and Experience Committee
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service De-escalated, risk being managed at Tier 2 Awaiting Confirmation of De-escalation at Quality, Safety and Experience Committee

Emerging risks

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		
CRR23-36	Cost of Living Impact on Staff and Patients - the risk associated with the impact of the increased cost of living on Staff and Patients and how that translates to the quality of Patient Care that BCUHB delivers	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-37	Targeted Intervention - risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care	Deputy Chief Executive (Proposed)	Quality, Safety and Experience	
CRR23-38	Workforce - The need to consolidate existing workforce risks into an appropriate described risk/risks that reflect the pan BCUHB position for the provision of services to patients. Also, to note a separate workforce risk related to statutory and regulatory requirements of being an employer	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-39	Patient Flow - Impact on Access and Quality of Care	Executive Director of Nursing and Midwifery (Proposed)	Quality, Safety and Experience	

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK – APRIL 2023

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score (impact x likelihood)	Current Risk Score (impact x likelihood	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
Strategic Aim 1: Improve physical, emotional and mental health and well-being for all/ Improve the safety and quality of all services													
1.1	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Failure to consistently provide safe provision of care to patients at YGC, resulting in significant harm to patients, poor patient experience and a high number of complaints and claims, as well as a loss of public confidence	Implementation of YGC improvement plan Journey to Excellence implementation	Vascular Steering Group, Vascular Quality panel, Quality Safety, Experience Committee, Cabinet oversight of YGC Improvement Plan	Health Inspectorate wales review of YGC ED in March , May and November 2022, Royal College Surgeons review of vascular services Internal audit review of YGC Governance in 2021, HIW review of YGC in November 2022	YGC improvement plan is in the process of being implemented, therefore sustained improvements require some time in order for effectiveness to be embedded. YGC ED and Vascular services are highlighted as services requiring significant improvement	All external assurance review of the YGC ED highlight gaps in compliance assurance, specifically: Health Inspectorate wales review of YGC ED, Royal College Surgeons review of vascular services	20 (4x5)	20 (4x5)	16 (4x4)	continue implementation of YGC improvement and Journey to Excellence plan	ongoing
1.2	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety , resulting in a deterioration of care and harm to patients and service users	Six Goals improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	Quality, Safety and Experience Committee oversight	Health Inspectorate wales review of YGC ED in March and May 2022, Royal College Surgeons review of vascular services Internal audit review of YGC Governance in 2021, HIW review of YGC in November 2022	Limited assurance on embedding HIW requirements in relation to the March and May 2022 inspections	The vascular service and ED are rated as 'requiring significant improvement' by HIW in March and May 2022 respectively YGC site was officially entered into the Targeted intervention framework as of June 2022	20 (4x5)	20 (4x5)	16 (4x4)	Implementation of HIW Action plan	
1.3	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience	Six Goals improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Performance, Finance & Performance. Governance Committee	Board, Performance, Finance and Information Governance and People, Partnerships and Population Health Committee oversight	none identified	Unscheduled care performance continues to be challenged, impacted by capacity and flow through hospitals, and a high number of medically fit for discharge patients. Delays to ambulance handover continue, resulting in poor experience and increased clinical risk across the system. Performance against 4 hour target has deteriorated to 55%	None identified	20 (4x5)	20 (4x5)	20 (4x5)	i) Working with IHC teams to support initiatives for UEC trajectory improvement in line with the 6 Goal Programme. ii) Support Welsh Government funding opportunities for high-risk patients iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise. v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative vi) Continue to drive technology support for the programme. vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR planning team.	
1.4	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee and Performance, Finance and Information Governance Committee	Risk of a consistent failure to meet performance targets, resulting in an adverse impact on patient experience and quality of care, as well as a loss in public confidence	Clinical harm reviews, management of overdue follow-up appointments, implementation of clinical prioritisation process. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 post P2 Breach. Harm review process. Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually	Performance assurance reports to QSE, PFIG and Board	none identified	Substantial challenges remain in delivering elective outpatient activity. There is a gap between capacity and demand in a number of specialties , which has widened since the pandemic	to be confirmed	20 (4x5)	20 (4x5)	16 (4x4)	ii) Support Welsh Government funding opportunities for high-risk patients – work also ongoing within each IHC to identify high risk patients in line with Goal 1 to co-ordinate planning for individuals at risk.	TBC

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK – APRIL 2023

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1.5	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm	Streamlining the processes through efficiencies, Creating additional capacity to see long waiting patients specifically around insourcing and outsourcing . Insourcing contract being finalised. Implementing and embedding schemes such as SOS and PIFU in order to ensure patients are seen within appropriate timescales, without exposing to clinical harm	Enhanced monthly meetings to focus solely on planned care performance chaired by the Director of Performance, with assurance feeding through to Performance, Finance and Information Governance Committee. revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Performance, Finance and Information Governance Committee. Introduction of further validation staff in Q3/4 non recurring complete. Review of validation techniques and validation SOP completed; now ready for deployment and adoption.	Audit Wales' review of planned care across North Wales, due to be presented to the Audit Committee in September 2022 Waiting list Limited assurance audit opinion internal audit report	Gaps in control were identified in the risk stratification process as part of the waiting list internal audit review	Adverse variation in Planned care performance	20 (4x5)	20 (4x5)	20 (4x5)	iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. Stakeholder meetings are almost complete and contracts being prepared. This is within Goal 2 (24/7 signposting for U&EC) – This is goal 1	
1.6	Executive Director of Public Health	Quality, Safety and Experience Committee	Risk of instability of the Mental Health leadership model due to unstable temporary staffing arrangements and high turnover of staff resulting in poor performance, a lack of assurance and governance, and ineffective service delivery.	Delivery of mental health improvement plan Interim senior management is currently in place alongside other key posts; Interim Director, Interim Director of Nursing, Interim Deputy Director and Interim Director of Operations. Each lead specific programmes and will further support and develop leadership, governance and management.] .Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team. Ongoing s are regularly reviewed by the Executive Director to ensure the model is effective in discharging its roles and responsibilities. Implementation of the Mental Health Strategy in a consistent manner across the Health Board		CHC review of Mental Health services Independent serious incident review	Mental Health improvement plan is still under development and therefore requires embedding	None identified	15 (5X3)	15 (5X3)	12 (4x3)	iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise.	
1.7	Executive Director of Public Health	Quality, Safety and Experience Committee	There is a risk to the safe and effective delivery of Mental Health services, leading to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.	Delivery of mental health improvement plan Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	Quality, Safety and Experience Committee oversight rtnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re	CHC review of Mental Health services	Mental Health improvement plan is still under development and therefore requires embedding	None identified	16 (4x4)	16 (4x4)	16 (4x4)	v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative	
2. Strategic Objective: Target our resources to people who have the greatest needs and reduce inequalities												vi) Continue to drive technology support for the programme.	
2.1	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health Committee	Failure to attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could adversely impact on the Board's ability to deliver safe and sustainable services.	Establishment Control Policy and system in place. Implementation of Roster management Policy. Implementation of Recruitment Policy. Review of Vacancy control process underway to establish a system for proactive recruitment against key staff groups/roles. Implementation of People strategy and plan 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. Workforce Service Review programme commissioned and commenced. Implementation of Safe Employment Policy.	Partnerships, People and Population Health Committee oversight. Monthly monitoring by People Executive Delivery Group	Pipeline reports produced monthly for review and action by managers across the organisation	National shortages in certain roles	Staff turnover rates	16 (4x4)	16 (4x4)	12 (4x3)	vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR planning team.	
2.3	Executive Director of Finance	Performance, Finance and Information Governance Committee	Inability to develop and implement a plan to incrementally reduce the recurrent deficit over the next 3/5 years and to secure WG income/cash support for in year deficits in the intervening period (including the potential loss of Strategic Support from 2024/25)	Case previously made to WG to continue Strategic Support funding Enabling approaches and action needed for financial improvement agreed, as identified in the 2023/24 budget(cross-cutting themes, further review of recent investments etc). Oversight arrangements agreed (subject to SMOG & Board approval) Financial control action plan for approval at Audit Committee May 15 New integrated planning and performance management framework agreed and being implemented in Q1	The Health Board has approved the initial financial plan for 2023/24 and the associated improvement actions to deliver the plan. The plan provides a small level of assurance that the organisation recognises the gravity of the financial positon in that the budget does reflect agreed dis-investments. The performance and transformation funding has largely been committed recurrently. Given there is a major to recover from the underlying deficit excluding any loss of Strategic Support, there is very little internal mitigation of this risk.	None identified	The key gaps in contol are that the further actions in financial improvement have been agreed but have not yet been implemented. A key focus over the remainder of Q1 is to get these actions into implementation.	2022/23 Internal Audit report providing no assurance on savings planning and delivery (recognising that this reflects the position prior to the changes in approach and leadership).	25 (5x5)	20 (5x4)	12 (4x3)	Action in the short term is focused primarily on implementing the actions agreed in the 2023/24 financial plan and increasing the probability of delivering and improving on the 2023/24 financial plan). Action will then need to move on to a more strategic consideration of use of resources (benchmarking against other organisations), and developing associated action plans for service change.	Initial check point end Q1 2023/24

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK – APRIL 2023

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance i.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score (impact x likelihood)	Current Risk Score (impact x likelihood	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
2.4	Executive Director of Transformation	Performance, Finance and Information Governance Committee	Failure to deliver an approved integrated medium term plan incorporating service, workforce, financial balance and delivery of key performance targets to Welsh Government (to ensure statutory duties are met) resulting in a regulatory audit opinion	Planning cycle established with outline BCUHB Planning schedule/overall approach for 2022/2025 - plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Partnerships, People & Population Health Committee.	Performance, Finance and Information Governance Committee oversight	none identified	2022/2025 IMTP not accepted by the Welsh Government	None identified	16 (4x4)	16 (4x4)	12 (4x3)	currently under review	
2.5	Chief Digital Information Officer	Partnerships, People and Population Health Committee	There is a risk that we won't achieve our strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled change. –This will lead to an inability to deliver new models of care in line with National and Local Strategies which results in a significant future degradation in patient safety, quality of care, public confidence, financial controls and reputation.	No controls yet in place subject to actions being delivered by newly appointed CDIO reviewing the current operating model and developing proposals and plans for its transformation into a minimum viable Digital, Data and Technology operation for the Health Board.	Annual Plan delivery assurance report to PPPH Committee	Benchmarking the service against external assessments. e.g. Gartner Group IT Score. NCSC. Cyber Essentials+ IG Toolkit Government Digital Service DDAT roles and possibly SFIA assessments.	Implementation of new DDAT operating model and structure including investment in skills and capabilities.	Plans, finance and resourcing not in place.	16 (4x4)	16 (4x4)	12 (4x3)	currently under review	
2.6	Chief Digital Information Officer	Partnerships, People and Population Health Committee	There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber attack. This will lead to compromised – safety and quality of care, reduced public confidence, reputational damage and, finance and regulatory non-compliance.	Cyber Security controls: Cyber Assessment Framework with Welsh Government. Monitoring tools to flag anomalies. Antivirus/Anti Ransomware software.	Annual Plan delivery assurance report to PPPH Committee	External expert independent review and assessment of the current environment.	Implementation of three-year Essential Services Programme to address the issues identified.	Plans, finance and resourcing not in place.	16 (4x4)	16 (4x4)	12 (4x3)	Develop and implement proposals for new operating model and its associated resource requirements and financial case once confirmation of IMTP received. This will include new functions for: Intelligence and insight, Digital PMO, Architecture Software engineering, Service design and clinical change , Governance arrangements	Commence Apr 2023
3. Strategic Objective: . Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being													
3.1	Executive Director of Finance	Partnerships, People and Population Health Committee	Failure to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.	Capital programme driven by risk assessed Divisional and Core Area strategic priorities. Prioritised capital plan reviewed and approved by the Capital Investment Group before submission to the Finance and Performance Committee for final approval. Risks are managed by the Core Areas and tracked via the compliance governance groups (i.e. Fire Safety and Water Safety Groups) that review specific risks and the mitigation being undertaken to reduce the risk. The Governance Committees report up to the Health and Safety Committee.	Performance, Finance and Information Governance Committee oversight of capital programme delivery, compliance sub-groups, Strategic Infection Prevention and H&S group	None identified	Delays in the alignment of the new Estates Strategy to the clinical services strategy and quality improvement strategy. There is an Estates Strategy but a full underpinning Clinical Strategy is still in development.	None identified	20 (5x4)	20 (5x4)	12 (4x3)	1. Implementation of capital programme and estates strategy. 2. Review of capital process to confirm that proposed capital projects are linked to documented risk and supported by Divisional Director. Project prioritisation, current mitigation and estates strategy alignment will form part of the CIG information to confirm delivery of the desired strategic outcomes i.e. reduce risk, align with estates strategy etc.	1. Ongoing. 2. Implemented by end of June 23, then ongoing.
3.2	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health Committee	Failure to implement and embed learning from experience in order to improve services, resulting in poor staff morale and a lack of trust and confidence in senior management, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board. This could be caused by a lack of clear mechanisms for raising concerns at any and every level.	Implementation of Speak out Safely Guardians report directly to CEO, with an independent board member to support and scrutinise Guardians' role Implementation of Raising Concerns Policy Implementation of SOP which includes agreed role outlines for Guardians, Speak out Safely Champions and independent member and terms of reference for MDT	Partnerships, People and Population Health Committee oversight.	none identified	Health inspectorate Wales review of YGC ED , highlighting concerns from staff about raising concerns arrangements	None identified	16 (4x4)	16 (4x4)	12 (4x3)	Implementation of people strategy and associated plan on staff engagement	

BETSI CADWALADAR UNIVERSITY HEALTH BOARD													
2022/23 BOARD ASSURANCE FRAMEWORK – APRIL 2023													
Risk Number	**Responsible Director**	**Assurance Committee**	**Principal Risk**	**Controls in place to manage risk (mitigation)**	**Internal assurances**	**External Assurances on controls**	**Gaps in control (where the controls are not working or further controls required)**	**Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)**	**Initial Risk Score (impact x likelihood)**	**Current Risk Score (impact x likelihood**	**Tolerable Risk Score (target by year end)**	**Action plan description**	**Action plan due date**
3.3	Executive Director of Integrated Health Care	Partnerships, People and Population Health Committee	Risk of significant delays to access to Primary Care Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital, resulting in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.	Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care. Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services. Primary Care Transformation Fund in place across the clusters to support local innovation in addressing planned care backlog in primary care	Partnerships, People and Population Health Committee oversight.		Primary care capacity remains a significant area of concern with: 213 GPs anticipated to retire in North Wales in next 5 years Number of practices identified as being 'at risk' of handing back contract Managed Practice costs pressures (circa £2.79m)		16 (4x4)	16 (4x4)	16 (4x4)	currently under review	
3.4	Executive Director of Public Health	Partnerships, People and Population Health Committee	Failure to effectively promote wellbeing and reduce health inequalities across the North Wales population, due to service model restrictions, resulting in demand exceeding capacity	Health Improvement & Reducing Inequalities Group (HIRIG) provides strategic direction and monitors delivery of the Population Health Services. Health Board commitment to establishing priority services including: Programme management and recruitment to posts. Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place. Fully integrated Smoking Cessation Service Delivery of Immunisation strategy (2018-2022) Delivery of Infant Feeding Strategy (2019-2022)	HIRIG provide reports nationally regarding expenditure and performance. regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact. Recent appointments of Consultants in Public Health have increased expertise and support across the region [3, one part time] Population Needs Assessment	1) Embed Public Health Outcomes approach into local planning through local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales. 3) Population Needs Assessment will provide local analysis for informing plans			15 (5X3)	15 (5X3)	12 (4x3)	Embed BCUHB North Wales population health priorities within its operational and strategic plans.	Dec-23
4. Strategic Objective: 3.1.6. Respect people and their dignity , and learn from their experiences												Implement programme and performance management	
4.1	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	Significant risk of avoidable harm to patients and staff, due to a failure by the Health Board provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation	Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group. Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE. Lessons Learnt analysis from COVID reported to Executive Team, through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures. Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire. RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews in excess of 820 RIDDOR investigations have been undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200+ site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. Robust fit testing programme now in place and the business case for the fit testing co-ordination team has been approved for two years. There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team.	Health and Safer Executive investigative reviews carried out in the 2021/22 period	There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3) Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. 4) Manual handling training compliance is currently at 50% there are insufficient trainers to train all new staff (approximately 800) at this time. We have appropriate premises and are advertising to increase capacity within the Team. 5) The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health. This may result in a prosecution against BCHB by the HSE under Section 3 of HASWA and fines in excess of £1m.	Notice of contravention issued to Health Board following an incident , may result in prosection	20 (4x5)	20 (4x5)	16 (4x4)	A clear strategy and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely has been implemented and Leading Safely Modules for Senior Leadership to be implemented. 3) Business case for secuirty provision approval process underway	Dec-22