

Bundle Audit Committee 7 May 2024

- 1 AC24.57 PRELIMINARY MATTERS
Audit Committee Agenda – Public – May 2024 V1.0f
- 1.1 09:30 – AC24.57.1 Apologies absence
- 1.2 09:31 – AC24.57.2 Declarations of interest
Chair – Decision – Verbal
- 1.3 09:34 – AC24.57.3 To receive and approve the unconfirmed minutes of the meeting held on 15th March 2024
Chair – Approval – Report
AC24.57.3 – DRAFT – Draft Minutes AC 15.03.24 – Public session V.05 (003)
- 1.4 09:39 – AC24.57.4 Action Log and matters arising not covered on the agenda
Chair – Approval – Report
AC24.57.4 – Table of Actions – Public Session – V5.0
- 1.5 09:44 – AC24.57.5 Notification of matters referred from other Committees
Chair – Approval – Verbal
- 1.6 09:47 – AC24.57.6 To note the items considered in the In-committee Audit Committee on 15th March 2024
Pam Wenger – Director of Corporate Governance – Noting – Verbal
- 1.7 09:49 – AC24.57.7 Audit Tracker: progress recommendations against External & Internal Audit Reports
Pam Wenger – Director of Corporate Governance – Assurance – Report Recommendation
The Committee is asked to;
 - *consider the proposed new processes around the introduction of new External and Internal Audit Reports to the Health Board*
 - *consider the proposed new audit recommendation closure approval process*
 - *note the current position with regards to open recommendations, those proposed for closure, and limited assurance recommendations*
 - *agree the Audit recommendations proposed for closure to be presented to Internal Audit for review*
 - *note the current position of overdue audit recommendations*
 - *approve for closure the recommendations from January which do not fall within the Audit Charter for Internal Audit approval; and*
 - *take assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations.*AC24.57.7a – Audit Committee 07.05.24 v1.00
AC24.57.7b – App 1 – January closed recommendations
AC24.57.7c – App 2 Follow Up Draft Audit Report_2022_23 reports_V1
AC24.57.7d – App 3 IA will not review
AC24.57.7e – App 4 Jan IA closed v1.00
AC24.57.7f – App 5 Final Follow Up Report_Jan 2024 AC
AC24.57.7g – App 6 awaiting IA review
AC24.57.7h – App 7 All recs March v1.00
AC24.57.7i – App 8 – March proposed closed v2.00
- 1.8 09:59 – AC24.57.8 Special Measures Update
Director of Transformation & Improvement – Assurance – Report
**Paolo Tardivel – Director of Transformation & Improvement, in attendance to present.*
Recommendation:
The Committee is asked to NOTE the Special Measures update and its transition into the Annual Delivery Plan, in terms of reporting, and the latest update regarding Independent Reviews.
AC24.57.8 – FINAL Audit Special Measures–2024–05–07
- 2 AC24.58 RISK MANAGEMENT
Pam Wenger – Director of Corporate Governance
**Nesta Collingridge – Head of Risk Management to present.*
- 2.1 10:09 – AC24.58.1 To receive for assurance a report from the:

*Chair of Risk Management Group
Board Assurance Framework
Corporate Risk Register, as at end of March 2024
Recommendation:*

The Committee is asked to note and receive assurance for:
• *Chair's Assurance Report from the Risk Management Group*
• *Board Assurance Framework*
• *Corporate Risk Register.*

Endorse changes highlighted around the Board Assurance Framework and realigning this to the Objectives of the Health Board, recently approved at the March Board.

AC24.58.1 – Audit Committee CRR and BAF Risk report Final v1

2.2 10:24 – COMFORT BREAK

3 AC24.59 FINANCE

3.1 10:34 – AC24.59.1 Breaches of SFIs and Scheme of Delegation
Russell Caldicott – Acting Executive Director of Finance – Approval – Verbal
Andrea Hughes – Interim Director of Finance

3.2 10:44 – AC24.59.2 23/24 Annual Conformance Report (1 April 23 to 31 March 24).
Russell Caldicott – Acting Executive Director of Finance – Approval – Report
Andrea Hughes – Interim Director of Finance
Recommendation

The Committee is asked to:

1. To note and discuss the below elements of performance

- *Purchase orders that are non-compliant with SFI's*
- *E-Waiver System Developments and Single Waivers*
- *Receivables and conformance with payroll procedures*
- *Payables and conformance with Public Sector Payment Policy (PSPP)*

2. Approve the Losses and Special Payments (January to March 2024) 3. Approve Consequential Loss, £1,519.08

AC24.59.2 – Audit Committee – Annual Conformance Report – 23.24

3.3 10:54 – AC24.59.3 Agree the content of the Annual Accounts meeting of the Audit Committee (Meeting to be held on 21 May 2024)
Chair – Information – Verbal

4 AC24.60 INTERNAL AUDIT

4.1 11:04 – AC24.60.1 To receive the Internal Audit Progress Report and Internal Audit Reviews Limited/No Assurance Reports in Full
Dave Harries – Head of Internal Audit – Assurance – Report
Nicola Thomas – Internal Audit
Recommendation

The Committee is asked to:

Receive the progress report.

Approve deferment of the Contracted patient services: Quality and safety arrangements (Follow up).

AC24.60.1a– IA progress report Cover Sheet_May24

AC24.60.1b – BCUHB Audit Committee progress report May 2024

AC24.60.1c – BCUHB Final Internal Audit Report Special Measures Contract Procurement

AC24.60.1d – Internal Audit – Deprivation of Liberty Safeguards (DoLS)

5 AC24.61 EXTERNAL AUDIT

Matt Edwards and Andrew Doughton – Audit Wales – to present.

5.1 11:19 – AC24.61.1 Audit & Risk Committee Update

Recommendation:

To receive the update.

AC24.61.1 – BCU Audit Committee Update 22042024

5.2 11:29 – AC24.61.2 Structured Assessment for 2023

Recommendation:

To receive the report.

AC24.61.2 – Structured Assessment 2023 BCUHB final

5.3 11:39 – AC24.61.3 Workforce Planning Report

Recommendation:

To receive the report.

AC24.61.3 – 3707A2023_BCU_Workforce_Planning_Report_Eng

5.4 11:49 – AC24.61.4 Audit Plan 2024

Recommendation:

To receive the Plan.

AC24.61.4 – BCUHB 2023–24 Audit Plan

- 5.5 11:54 – AC24.61.5 To receive a verbal update on :
National audit reports
National Accounts update for information
- 5.6 11:59 – COMFORT BREAK
- 6 AC24.62 COUNTER FRAUD
- 6.1 12:14 – AC24.62.1 Local Counter Fraud – Verbal Report
Karl Woodward – Head of Local Counter Fraud – for information
Sjef Molmans – Local Counter Fraud Specialist, Finance
- 7 AC24.63 CLOSING BUSINESS
- 7.1 12:24 – AC24.63.1 Agree Items for referral to Board / other Committees
Committee Members – For decision – Verbal
- 7.2 12:27 – AC24.63.2 Chairs Assurance Report
Chair – for decision – Verbal
To agree items for inclusion in the report;
To agree any items for escalation to Board/Committees
- 7.3 12:30 – AC24.63.3 Review of Meeting Effectiveness
Committee Members – For decision – Verbal
- 7.4 12:33 – AC24.63.4 Date of Next Meeting – 18th July 2024
- 8 12:34 – AC24.64 Exclusion of Press and Public
Resolution to Exclude the Press and Public –
"That representatives of the press and other members of the public be excluded from the remainder
of this meeting having regard to the confidential nature of the business to be transacted, publicity on
which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies
(Admission to Meetings) Act 1960."

Public Agenda for Audit Committee

Date 7 May 2024
Time 09:30 -12:30
Location Boardroom, Carlton Court
Chair Karen Balmer

| Agenda item | Timing | Item | Lead | Action | Paper/ Verbal |
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| 1.0 PRELIMINARY MATTERS | | | | | |
| 1.1 | 1 min | Apologies absence | Chair | Information | Verbal |
| 1.2 | 3 mins | Declarations of Interest | Chair | Decision | Verbal |
| 1.3 | 5 mins | To receive and approve the unconfirmed minutes of the meeting held on 15th March 2024 | Chair | Approval | Report |
| 1.4 | 5 mins | Action Log and matters arising not covered on the agenda | Chair | Approval | Report |
| 1.5 | 3 min | Notification of matters referred from other Committees | Chair | Approval | Verbal |
| 1.6 | 2 mins | To note the items considered in the In-committee Audit Committee on 15 th March 2024 | Director of Corporate Governance | Noting | Verbal |
| 1.7 | 10 mins | Audit Tracker: progress recommendations against External & Internal Audit Reports | Director of Corporate Governance | Assurance | Report |
| 1.8 | 10 mins | Special Measures Update | Director of Transformation & Improvement | Assurance | Report |
| 2.0 RISK MANAGEMENT | | | | | |
| 2.1 | 15 mins | To receive for assurance a report from the <ul style="list-style-type: none"> a) Chair of Risk Management Group b) Board Assurance Framework c) Corporate Risk Register | Director of Corporate Governance / Head of Risk Management | Assurance | Report |
| COMFORT BREAK – 10 MINS | | | | | |

| FOR ASSURANCE | | | | | |
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| 3.0 FINANCE | | | | | |
| 3.1 | 10 mins | Breaches of SFIs and Scheme of Delegation | Interim Executive Director of Finance | Approval | Verbal |
| 3.2 | 10 mins | 23/24 Annual Conformance Report (1 April 23 to 31 March 24). | Interim Executive Director of Finance | Approval | Report |
| 3.3 | 10 mins | Agree the content of the Annual Accounts meeting of the Audit Committee (Meeting to be held on 21 May 2024) | Chair | Information | Verbal |
| 4.0 INTERNAL AUDIT | | | | | |
| 4.1 | 15 mins | To receive the Internal Audit Progress Report Internal Audit Reviews Limited/No Assurance Reports in Full | Internal Audit | Assurance | Report |
| 5.0 EXTERNAL AUDIT | | | | | |
| 5.1 | 10 mins | Audit & Risk Committee Update | Audit Wales | Approval | Report |
| 5.2 | 10 mins | Structured Assessment for 2023 | Audit Wales | Information | Report |
| 5.3 | 10 mins | Workforce Planning Report | Audit Wales | Information | Report |
| 5.4 | 5 mins | Audit Plan 2024 | Audit Wales | Assurance | Report |
| 5.5 | 5 mins | To receive an update on : <ul style="list-style-type: none"> National audit reports National Accounts update for information | Audit Wales | Information | Verbal |
| COMFORT BREAK – 15 mins | | | | | |
| 6.0 COUNTER FRAUD | | | | | |
| 6.1 | 10 mins | Local Counter Fraud Report | Head of Local Counter Fraud | For information | Verbal |
| 7.0 CLOSING BUSINESS | | | | | |
| 7.1 | 3 mins | Agree Items for referral to Board / other Committees | Committee Members | For Decision | Verbal |
| 7.2 | 3 mins | Chairs Assurance Report | Chair | For Decision | Verbal |

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| | | <ul style="list-style-type: none"> To agree items for inclusion in the report; To agree any items for escalation to Board/Committees | | | |
| 7.3 | 3 mins | Review of Meeting Effectiveness | Committee Members | For Decision | Verbal |
| 7.4 | 1 min | Date of Next Meeting – 18 th July 2024 | Secretariat | Information | Verbal |

**Betsi Cadwaladr University Health Board
Draft Minutes of the Audit Committee
15 March 2024, Boardroom, Carlton Court, St Asaph**

| Present | |
|----------------------|---|
| Name | Title |
| Karen Balmer | Independent Member (IM), Chair |
| Urtha Felda | Independent Member |
| Dyfed Jones | Independent Member (<i>Part Meeting – in attendance from item ref AC24.39</i>) |
| In attendance | |
| Chris Lynes | Deputy Executive Director of Nursing |
| Dave Harries | Head of Internal Audit |
| Ffion Johnstone | Integrated Health Community Director (West) - (<i>Part Meeting</i>) - Via Virtual Link. |
| Fflur Jones | Audit Lead, Audit Wales |
| Glesni Driver | Head of Covid-19 Inquiry |
| James Risley | Deputy Executive Medical Director |
| Jody Evans | Corporate Governance Officer – Secretariat |
| Nesta Collingridge | Head of Risk Management |
| Nicola Jones | Deputy Head of Internal Audit |
| Pam Wenger | Director of Corporate Governance (in post as from 01.04.2024) - Via Virtual Link |
| Paolo Tardivel | Director of Transformation & Improvement (<i>Part Meeting</i>) |
| Phil Meakin | Acting Board Secretary |
| Russell Caldicott | Interim Executive Director of Finance |
| Simon Monkhouse | Audit Lead, Audit Wales |
| Sjef Molmans | Local Counter Fraud Specialist |

| Agenda item | Action |
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| OPENING BUSINESS | |
| <p>1.1 AC24.34 Welcome, introductions and apologies for absence</p> <p>AC24.34.1 The Chair of the Committee welcomed everyone to the meeting.</p> <p>AC24.34.2 Apologies were received from; Angela Wood, Executive Director of Nursing – Chris Lynes, Deputy in attendance. Adele Gittoes, Executive Director of Operations - Ffion Johnstone, Deputy in attendance. Karl Woodward, Head of Counter Fraud - Deputy Sjef Molmans Deputy in attendance.</p> <p>AC24.34.3 – In attendance remotely; Pam Wenger, observing following appointment to the role Director Corporate Governance 01/04/2024, James Risley, Deputy Executive Medical Director and Ffion Johnstone, Integrated Health Community Director (West).</p> <p>AC24.34.4 The Chair and Committee provided Pam Wenger, Director of Corporate Governance (starting with the Health Board 1st April 2024) with a warm welcome.</p> <p>AC24.34.5 Those in attendance introduced themselves.</p> | |
| <p>AC24.35 Declarations of interest on current agenda</p> <p>AC24.35.1 No declarations of interest were made at the meeting.</p> | |
| <p>AC24.36 Minutes of previous meeting for accuracy and review of summary action plan</p> <p>AC24.36.1 RESOLVED: That; the Minutes of the last meeting of the Committee held on 12.01.2024 be confirmed as a correct record subject to Minute AC24.20 - <i>missing word</i> (Audit) in relation to the title of Internal <i>Audit</i>.</p> <p>AC24.36.2 RESOLVED: That; updates to the summary action log be recorded therein.</p> | |
| <p>AC24.37 Notification of matters referred from other Committees Phil Meakin, Acting Board Secretary - for decision.</p> <p>AC24.37.1 There were no matters referred from other Committees noted at the meeting.</p> | |



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

GOVERNANCE

DRAFT



AC24.38 Special Measures Progress Update on relevant areas

Paolo Tardivel - Director of Transformation & Improvement present the item.

AC24.38.1 This report provided an update on the progress made against the Health Boards Special Measures Progress, which reflected the deliverables associated to the Committee within Cycle 3 (December 2023 to February 2024). The Committee received assurance on the progress to date whilst acknowledging the challenges and risks to delivery.

AC24.38.2 Members acknowledged the progress update and particularly the progress of the Office of the Board Secretary (78% compliance to date).

AC24.38.3 The Committee also recognised the ongoing work of the Risk Management Team and appointment of the Director of Corporate Governance to support and compliment the Structure of the Team going forward.

AC24.38.4 The final report into the stocktake progress review against previous Mental Health reviews was received by The Acting Board Secretary and would progress through the relevant Committee responsible for independent reporting, in order to instigate the Management Response.

AC24.38.5 The Director of Transformation & Improvement drew attention to the delays of some reviews, which had however been proactively completed.

AC24.38.6 Members noted the assurance comments within the Action Plan, along with areas awaiting completion, updates were noted and included that; the Committee Business Management Group was being reconvened. The Acting Board Secretary also confirmed that the confirmations of Independent Member positions upon Committees as work in progress. The Committee also acknowledged that the Policy for the Management of Health Board wide Policies was an Agenda item at Committee for consideration and approval.

AC24.38.6 The Committee were informed of the revised date for the action plan to support the development session as being the end of March 2024.

RESOLVED: That

the Committee received assurance on the progress to date, acknowledging the challenges highlighted and risks to delivery.



AC24.39 Risk Management

Phil Meakin, Acting Board Secretary / Nesta Collingridge, Head of Risk Management - for assurance.

AC24.39.1 The Head of Risk Management presented the reports which summarised details in relation to:

- The Chair's Assurance Report from the Risk Management Group
- Board Assurance Framework (BAF).
- Corporate Risk Register.

AC24.39.2 The Head of Risk Management invited questions and the Chair expressed thoughts in relation to the improvements to the dashboards, suggesting that more narrative would be helpful with regard to a change in a risk's trajectory.

AC24.39.3 UF (IM) also commented and stated that the reports were much clearer; however, development to the grading of risks may require further detail.

AC24.39.4 The Interim Executive Director of Finance also provided positive feedback into the layout and presentation, whilst expressing the need to target the level of detail.

AC24.39.5 Chair also commented that there was a need to differentiate between a gap in control and a "state of affairs", the latter which should not be cited as a gap in control in the table. The Chair added that it would be good practice to include a due date on SP1 and in time for the committee to consider the impact of all the actions as part of this reporting and assurance process.

AC24.39.6 Gaps in control were commented upon into financial constraints. A discussion ensued to suggested improvements, along with how gaps in controls were being addressed and articulated. The Head of Internal Audit stressed the Board and Committees should not be a line of defence. UF (IM) questioned reporting rates across the East, Central and West areas, along with logical connections to actions across the Health Board. A discussion ensued and the detail was noted.

AC24.39.7 In relation to BAF item SP18, the Chair commented on embedded learning and the deadline of December 2023. It was noted that there had been some delays and the forecast deadline was now June 2024. It was confirmed that the Risk Team were in the process of updating the corporate risks, which would embed the updates and that they would be included within the forthcoming report to Health Board. A discussion took place concerning the observation of ownership resting with the Executives, along with oversight into the maintenance of risks. The Acting Board Secretary confirmed that the Executive Team continually review risks (bi monthly), via the Executive Team Meetings, and also clarified the

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| <p>Chief Executive has insight and a keen view, in terms of actions and ownership in relation to the Executive Team.</p> <p>AC24.39.8 The Committee also discussed the repository of learning. The Deputy Executive Director of Nursing confirmed that training was not a quick fix and the culture and human factors would require time to progress. It was explained that the 12-18 month journey to embed the repository would go live in April 2024. The Committee noted the ongoing significant work. It was agreed to share the paper in relation to the updates, which was being taken to a Quality, Safety Experience Committee Meeting. UF (IM) requested detail pertaining to training links to the Transformation Team. It was confirmed to UF of the links to section 5 of the special measures update; evidenced learning.</p> <p>AC24.39.9 Chair provided comment in relation to; the Corporate Risk Register item ref CRR24-05 – Financial Planning, around the assurances from the Performance, Finance and Information Governance Committee /Audit Committee. It was reiterated that Committee functions were not a line of defense. It was agreed for The Head of Risk Management to review the Line of Defense.</p> <p>AC24.39.10 <i>Dyfed Jones (Independent Member) entered the meeting. The Chair, Members and attendees welcomed DJ to the Committee.</i></p> <p>RESOLVED: That; the Committee noted and received assurance for:</p> <ul style="list-style-type: none"> · Chair’s Assurance Report from the Risk Management Group (full assurance). · Board Assurance Framework (BAF) full assurance. Feedback provided by the Committee, in terms of the second lines of defence. · Quality of the population of the board assurance framework, to be improved in line with board effectiveness and special measures. · Corporate Risk Register (partial assurance). · The discussions, which derived from the BAF & Corporate Risk Register. | <p>CL</p> <p>NC</p> |
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| <p>AC24.40 Corporate Governance Phil Meakin - Acting Board Secretary presented the report.</p> <p>AC24.40.1 The Acting Board Secretary presented The Corporate Governance report.</p> <p>AC24.40.1.1 Details of Breaches to Publication of Board and Committee Papers; the Acting Board Secretary drew attention to the detail within appendix 1 of the report and reported 3 breaches had been recorded since the last Audit Committee. Discussion ensued concerning the improved position and the committee noted that the special measures, interim standard of 5-days had been met. The Acting Board Secretary agreed to provide a visual graph in future reports outlining the data. The Chair requested that the information be provided on a cumulative basis.</p> <p>AC24.40.1.2 The Acting Board Secretary presented the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, it was agreed to approve the document, subject to minor updates to Job Titles. The Acting Board Secretary agreed to update the Policy document with the Director of Corporate Governance, as per the minor updates as agreed.</p> <p>AC24.40.1.3 The Secretariat (JE) also explained to UF (IM) in response to a question; regarding the various Impact assessments around written control document production, along with incorporation of consultations and engagement.</p> <p>AC24.40.1.4 The Committee were also provided with an update on the work underway on updating written control documents across the Health Board. The Acting Board Secretary proposed to report back to the Committee in May 2024, in relation to the progress to outstanding policies for review.</p> <p>AC24.40.1.5 The Acting Board Secretary provided the brief update on the Review of Gifts & Hospitality and Declarations of interest Registers and confirmed that a full report would be reported back to the Audit Committee in May.</p> <p>AC24.40.1.6 Ongoing work with the Civica – Declare System; significant progress was highlighted, along with the forthcoming Internal Audit Review.</p> <p>AC24.40.1.7 Validation of Declarations was also discussed. It was confirmed that a piece of work had been commenced into the review of persons registered with Company House. The Counter Fraud Lead clarified the approach of the work in relation to the national fraud initiative and the work with suppliers on oracle and</p> | <p>PM</p> <p>PM</p> <p>PM</p> |
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| <p>matches with the ESR system. The requirement to declare was discussed along with the legalities aligned with duties to report.</p> <p>AC24.40.1.8 Following the discussions, the Deputy Board Secretary noted the requirement to remind and further communicate and approach staff to update their declarations.</p> <p>RESOLVED; that <i>The Committee:</i></p> <ul style="list-style-type: none"> · Noted the report on breaches to Board and Committee agenda and papers. · Noted and Approved in principle the “Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents.” subject to minor updates to Job Titles. · Noted the progress being made on updating policies. · Noted the update on Declarations of Interest and Gifts and Hospitality. | <p>PM</p> |
| <p>FINANCE</p> | |

DRAFT



AC24.41 & 42 Breaches of SFI's, Scheme of Delegation and Standing Orders (SO's)

Russell Caldicott, Interim Executive Director of Finance - for assurance.
Verbal.

AC24.41 & 42.1 The Interim Executive Director of Finance provided a verbal update in relation to the Breaches of SFI's, Scheme of Delegation and SO's, along with the SFI Conformance Report, in relation to the period ending December 2024.

AC24.41 & 42.2 It was confirmed that a written report was planned to be provided to the May 2024 Audit Committee.

RESOLVED: That;

The written report be provided at the Audit Committee in May 2024.

DRAFT



AC24.43 Key Judgements and Annual Timetable 23-24 Draft Final Accounts

Russell Caldicott, Interim Executive Director of Finance - report *for approval*.

AC24.43.1 The Interim Executive Director of Finance provided the Committee with the Key Judgements and Annual Timetable 23-24 Draft Final Accounts Report.

AC24.43.2 *The Committee* noted the engagement that occurred with Audit Wales post submission of the 2022/23 Annual Accounts, the work undertaken throughout the year and further the timeframe, key dates for review, Audit and submission of the 2023/24 Annual Accounts.

AC24.43.3 Members and attendees also noted the initial key areas where the values recorded in the 2023/24 Annual Accounts were based on judgement. It was recognised that further detail would be shared at the planned Audit Committee Development Session on the 21st May 2024.

AC24.43.4 Discussion ensued with regards to the Welsh Risk Pool, Continuing Health Care, along with Annual leave accrual. It was confirmed that detail in terms of liabilities had been shared with audit colleagues, along with confirmation around the usage of debt collection agencies.

AC24.43.5 Chair questioned whether annual leave due to Covid had been utilised in the carry over. It was noted that all Covid related carry over of leave had been utilised by employees.

AC24.43.6 UF (IM) also questioned the levels of exposure costs, in terms of Welsh Risk Pool payments and it was confirmed by the Interim Executive that penalties are thought to be linked to risk management and exposed costings. Interim Executive to clarify and feedback to UF (IM).

RESOLVED; That *the Committee*:

- Noted the engagement that had occurred with Audit Wales post submission of the 2022/23 Annual Accounts, the work undertaken throughout the year and further the timeframe, key dates for review, Audit and submission of the 2023/24 Annual Accounts.
- Noted the initial key areas where values recorded in the 2023/24 Annual Accounts are based on a judgement (estimation). Further details would be shared at the planned Audit Committee Development Session on the 21st May 2024.

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| <p>AC24.44 Counter Fraud Report (Matters for Public) Sjef Molmans - Local Counter Fraud Specialist - <i>for assurance on behalf of Karl Woodward Head Of Local Counter Fraud Services, Finance</i></p> <p>AC24.44.1 The Local Counter Fraud Specialist thanked the Chair of the Audit Committee for the opportunity to provide the verbal update to the March Audit Committee.</p> <p>AC24.44.1.1 It was noted that the Local Counter Fraud Service Team was undertaking preparation work for the Counter Fraud Functional Standard Return (CFFSR) planned for electronic submission by the deadline 31st of May. The Local Counter Fraud Specialist explained the Counter Fraud Functional Standard Return enabled NHS organisations to produce formal self-reviews of work undertaken to counter fraud, bribery and corruption and to also demonstrate compliance against each of the individual NHS requirements of the Government Functional Standard GovS013: Counter Fraud.</p> <p>AC24.44.1.2 The Committee acknowledged that NHS Counter Fraud Authority (NHS CFA) launched the Procurement Local Proactive Exercise for 2024/25. It was noted that the Health Board was requested to complete the exercise in a six-month period and formally report the findings.</p> <p>AC24.44.1.3 The Local Counter Fraud Specialist informed the Committee that the Local Counter Fraud, Bribery and Corruption Policy for the Health Board was due for review in August 2024. It was agreed to initially review and consider the policy at a future Audit Committee. The Committee also noted the new draft guidance of failure to prevent fraud and the need to review the investigation process following an employee departure from the Health Board.</p> <p>AC24.33.2 Mandatory Counter Fraud Awareness Training – The Committee recognised the excellent progress made to date, concerning the Counter Fraud Awareness training going live within the Health Board. The Committee congratulated the Counter Fraud Team on the achievement.</p> | <p>Agenda item – future Audit Committee</p> |
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| INTERNAL AUDIT REPORTS | |
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| <p>AC24.45 Internal Audit Reports Dave Harries, Head of Internal Audit - <i>Presenting</i>. Nicola Jones - Deputy Head of Internal Audit – <i>Presenting</i>. Russell Caldicott Executive Director of Finance - (Audit Report Reviews).</p> <p>AC24.45.1 The Head of Internal Audit presented the internal audit plan for the period April to September 2024/25. (Which included details pertaining to the risk based planned reviews for the first six months of the financial year; following review of the Board and Committee papers, BAF, CRR and risk based meetings with IMs and Executive Directors, along with reviews deferred from 2023/24).</p> <p>AC24.45.2 It was explained that the Health Board had adopted the plan and thanked staff whom engaged in the delivery.</p> <p>AC24.45.3 A discussion took place concerning the risk-based elements of the plan and in particular the fire safety risks and timescales. The Head of Risk Management confirmed the risk was live within Datix, along with an overarching estates risk, which was now approved and would be notified to the Risk Management Group in April 2024. The Head of Risk Management agreed to provide feedback to internal audit by the May Audit Committee.</p> <p>AC24.45.4 It was raised that the Clinical audit plan was subject to a follow up review of the recent limited assurance report. It was noted of the requirement to refresh the risk and update the Committee therein the October to March 2025 plan</p> <p>AC24.45.5 The Chair raised a question concerning the Value Based Health topic in relation to the procurement and budget plan. The Head of Internal Audit explained there was a direct allocation against value based health care and confirmed that a review would be undertaken concerning the achievements and delivery.</p> <p>AC24.45.6 Chair recognised that contract and procurement were within the 1st 6 months of the plan and it was confirmed to be upon the 2nd part of the financial year, to allow time for the special measures report to gain formal adoption; the Committee were conscious that finance had been working actively on implementation.</p> <p>AC24.45.7 The Committee noted and approved the Internal Audit Charter with the addition of the CEO as an escalation point (except where CEO is an auditee) for delayed management responses to audit reporting, and of the title change of Board Secretary to Director of Corporate Governance.</p> | <p>NC</p> <p>NC</p> |



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| <p>AC24.45.8 The Deputy Head of Internal Audit presented the internal audit reports in relation to Follow-up: Delivery of Health Board Savings and the Water Safety Report.</p> <p>AC24.45.8 A discussion took place with regards to delivery of health board savings and transformation along with planned target savings. It was acknowledged that the report had been confusing with regards to the legacy issues and The Interim Executive Director of Finance stated that the Finance Team were monitoring the output throughout the year.</p> <p>AC24.45.9 Discussions arose relating to the water safety report and responsibilities of areas; following a discussion <i>compliance was recognised to be with nursing and facilities</i>. The Deputy Executive Director of Nursing provided an overview of how the issues were dealt with from a nursing and infection control perspective. Training provision was also raised as a concern by the Chair. It was then explained that training was being promoted by the Strategic Infection Prevention and Control Group. The Interim Executive Director of Finance agreed to gain further insight into the area responsibilities and risk sharing between Facilities staff.</p> <p>AC24.45.10 <i>Ffion Johnson joined the meeting. The Chair and Attendees welcomed FJ.11:50am</i></p> <p>AC24.45.11 CITO programme – The Committee members and attendees expressed their congratulations on the achievement of the substantial audit report.</p> <p>AC24.45.12 Attention was drawn to the Health and Safety report in relation to the Executive Action Owner. It was also pointed out that the current Health & Safety Policy was overdue for review. It was confirmed that by default, the Chief Executive Officer is the Executive Lead/Owner in relation to the Audit Recommendations. It was therefore agreed to follow up the urgency to update the out of date Policy, in order to comply with the recommendation.</p> <p>AC24.45.13 The Executive Director of Finance provided an explanation in relation to the challenges and difficulties in delivery; relating to the budgetary controls and delays raised by the Chair. It was confirmed that the audit was now underway.</p> <p>AC24.45.14 The issue of non, or lack of compliance in responses to audits was highlighted by internal audit. The Acting Board Secretary expressed his apologies for the lack of engagement in some areas and it was agreed to raise the issue at the Executive Team Meeting.</p> | <p>RC</p> <p>PM,CEO</p> <p>PM</p> |
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RESOLVED: That; the Committee:

- Approved the six-month Internal Audit Plan for April to September 2024.
- Noted the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2024/25.
- Approved the Internal Audit Charter with the addition of the CEO as an escalation point (except where CEO is an auditee) for delayed management responses to audit reporting and title change of Board Secretary to Director of Corporate Governance.
- Noted the associated Internal Audit Key Performance Indicators.
- Received the progress report.

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| <p>AC24.46 Audit Recommendations Tracker Phil Meakin, Acting Board Secretary / Nesta Collingridge, Head of Risk Management - for assurance.</p> <p>AC24.46.1 The Committee were provided with an overview of the Report and Audit Tracker. The considerable amount of work, which had taken place since the last meeting was recognised by the audit Committee. It was noted that the Internal and External Audit recommendations for closure had also been discussed at the Executive Team meetings.</p> <p>AC24.46.2 The Committee noted the current position of the overdue audit recommendations and took assurance of the tracking and the proposed recommendations for closure. It was confirmed that the recommendations for closure, (which had been taken to the last Audit Committee) were with Internal Audit for final closure, pending review of the evidence provided. A log of the recommendations for closure signed off by Internal Audit would form part of the future reporting on this agenda item</p> <p>AC24.46.3 Questions were invited. The Chair recognised and reported upon an error within the statistics. It was agreed to correct the error therein the report.</p> <p>AC24.46.4 <i>In attendance to update the Committee;</i> The Deputy Executive Director of Nursing provided an update on behalf of the Executive Director of Nursing and Midwifery and provided updates against outstanding recommendations. It was acknowledged that recommendations which were pending had now started that there were no overdue recommendations due.</p> <p>AC24.46.4.1 The Acting Executive Finance Director reassured the Committee regarding the contractual recommendations and confirmed that the Finance Team regularly meet with the contracting team and acknowledged the challenges around environmental and operational management.</p> <p>AC24.46.4.2 UF (IM) requested further detail in relation to the Community Health Council and the ongoing national works timeline. The Executive Director of Finance clarified that the health board were looking into the next stages on a national level in relation to the value to access the training packages. The continued engagement and plans under development was noted.</p> <p>AC24.46.5 <i>In attendance to update the Committee;</i> Integrated Health Community (IHC) Director (West), provided an update on behalf of the Interim Executive Director of Operations and provided updates against outstanding recommendations.</p> | <p>NC/GD</p> <p>NC/GD</p> |
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| <p>AC24.46.5.1 The IHC Director informed the Committee of the variety of audits undertaken, in terms of performance and stated that the Associate Director for Emergency Care (interim), was working through the on call actions.</p> <p>AC24.46.5.2 It was noted that an extension to the Urgent primary care actions may be considered, due to an updated service model.</p> <p>AC24.46.5.3 Updated ownership (to be agreed) of the GP out of hours recommendations was raised. It was agreed for the IHC Director and the Head of the Covid Inquiry to confirm and update the Tracker details.</p> <p>AC24.46.5.4 With regards to engagement and updates; it was agreed to invite the Head of Risk Management and the Head of the Covid Inquiry to the Operational Leadership Team Meeting to instigate updates to outstanding actions.</p> <p>AC24.46.5.5 To further note, it was stated by the Audit Committee Chair that; a meeting with the Assoc Director for Emergency Care (Interim) was arranged, in order to discuss the outstanding recommendations. The Head of Internal Audit explained to the Committee of the pre dating issues surrounding the recommendations.</p> <p>AC24.46.5.6 At this point in the meeting, a discussion ensued concerning the significant risk issues relating to the Gold, Silver and Bronze On Call Duties. It was stressed that compensatory rest had not been progressed. It was agreed to raise the risk and issues in relation to staff wellbeing therein the Chairs Report to Board and it was agreed to recirculate the internal audit report.</p> <p>AC24.46.6 The Committee further commented upon the tracker and it was confirmed that all closures of recommendations were taken to the Executive Team Meetings and Internal Audit for extended scrutiny. The Chair commented upon the tracker as a whole, and suggested that the Internal and External Audits be placed upon separate documents for the next financial year. Chair also informed the Committee of her findings from reviewing the report and tracker documents and of a recent mapping exercise which had been undertaken. The refinement suggestions were taken on Board by the Committee, and it was noted that in future, the reports would be condensed and easier to manage</p> <p>The Acting Board Secretary also shared detail in relation to the future publication of the structured assessment report, which would to be shared upon publication.</p> <p>RESOLVED: That <i>the Committee:</i></p> | <p>GD</p> <p>FJ/NC/GD</p> <p>Chairs report to Board</p> <p>NC/PM</p> <p>NC/GD</p> |
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| <ul style="list-style-type: none">· noted the current position (February 2024) of overdue audit recommendations· Took assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations.· Considered the proposed recommendations for closure.· Representatives in attendance to represent the Executive Director of Nursing and Executive Director of Operations, and provided the relevant updates to updates pertaining to their areas.· Concern was noted on the overdue recommendation and associate risk in relation to “on call” (Gold, Silver and Bronze) out of hours relating to compensatory rest periods. | |
| EXTERNAL AUDIT | |

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| <p>AC24.48 Audit & Risk Committee Update Fflur Jones, Audit Wales Lead - <i>for update and discussion.</i></p> <p>AC24.48.1 The Audit Wales Lead (FJ) provided the Committee with an update in relation to External Audit and Risks pertaining to the Committee. The summary report was noted with regards to the status of current and planned accounts audit work, along with the status of current and planned audits</p> <p>AC24.48.2 Following the update it was explained by the Audit Wales Lead (SM) that the Audit Team met regularly to incorporate risks into audit planning, along with training being provided to Finance Staff. It was confirmed that audit work with regards to charitable funds was near completion. Attention was also drawn to the Planned care Audit and focus of the commencement date being under consideration.</p> <p>RESOLVED: That The Committee noted the report and response.</p> | |
| <p>AC24.49 Board Effectiveness Follow up Fflur Jones, Audit Wales Lead - presented the item for information.</p> <p>AC24.49.1 The Board Effectiveness follow up report was presented which provided the Audit Committee with key detail into the follow-up review of the board effectiveness report, along with the Health Board's response to the report's findings and recommendations which had previously been taken to the Private Health Board Meeting.</p> <p>AC24.49.2 The Acting Board Secretary confirmed the report was be noted at the Public Health Board Meeting in March, within the Chief Executives update report. It was also confirmed that the report had been published on the Audit Wales Web Site. The Director of Corporate Governance expressed the importance of the report, in terms of governance and how the report had been structured in terms of accountability.</p> <p>RESOLVED: That The Committee noted the report and response.</p> | PM |
| AUDIT COMMITTEE | |
| <p>AC24.50 Briefings and Update Sessions (As Appropriate) Chair/Acting Board Secretary - for information</p> <p>AC24.50.1 Nothing to report.</p> | |
| CLOSING BUSINESS | |

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| <p>AC24.51 Agree Items for referral to Board / other Committees Chair - for information</p> <p>AC24.51.1 Items for referral to other Committees were agreed as follows: On call arrangements to be raised with the People and Culture Committee regarding recommendations to compensation / rest periods.</p> | PM |
| <p>AC24.52 Review of Risks emerged in the meeting for referral to Risk Management Group Chair - for information</p> <p>AC24.52.1 Review of Risks emerged in the meeting for referral to Risk Management Group as follows;</p> <ul style="list-style-type: none"> · Risks in relation to subcontracting, quality and controls. · Concerns raised around the risk to the Health Board around overdue Health & Safety Policy further assurances being sought on effective review of the policy and Internal Audit recommendations. · On Call Duty documents detailing compensatory rest had not been progressed and is now overdue as a recommendation from Internal Audit. It was agreed to raise the risk and issues in relation to staff wellbeing therein the Chairs Report to Board and it was agreed to recirculate the internal audit report. | NC |
| <p>AC24.53 Agree items for Chairs Assurance Report Chair - for information</p> <p>The items were agreed and noted.</p> | |
| <p>AC24.54 Review of Meeting Effectiveness Members - for information.</p> <p>AC24.54.1 The Members and attendees discussed the effectiveness of the meeting.</p> <p>AC24.54.2 It was agreed that the sound quality was adequate. The Members recognised opportunities to undertake deep dives into risks, which arose from the valued discussions. It was agreed that the agenda required review, in order to get the best out of the meeting.</p> | Chair/NC |
| <p>AC24.55 Date of Next Meeting - 7th May 2024</p> | |

AC24.56 Exclusion of Press and Public
Resolution to Exclude the Press and Public –

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

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AUDIT COMMITTEE
TABLE OF ACTIONS LOG – ARISING FROM MEETINGS HELD IN PUBLIC

| | Lead Executive / Member | Minute Reference and Action Agreed | Original Timescale Set | Update | Revised timescale/ Action status (O/C) | RAG status |
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| Actions from 13 January 2023 | | | | | | |
| 1. | Associate Director of Governance | Charitable Funds - AC23.08.5G The role of the Charity would be discussed at the Audit Committee Workshop in May. | 15-May-2023 | This action remains outstanding due to the change in membership. New date to be set. 15.03.24 Agreed for closure. Meeting arranged with a guidance note to reflect conversations. | Item proposed for closure | |
| 10. | Associate Director of Governance | AC23.93 National Audit Report for information - The Acting Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising. | Nov 2023 | Acting Board Secretary updated the Executive Team work plan - for inclusion by end of November 2023 05.03.24 Tabled at the Executive Team (ET) Meeting of the 13 March 2024. <i>Proposed for closure</i> – Acting Board Secretary to confirm item is agreed at ET. 15.03.24 Item not agreed for closure - Closure of this item is dependent upon the work plan being agreed at the Executives Meeting. 16.04.2024 – Item to be kept open – To continue to monitor and focus on historical data in relation to learning and progression. Associate Director of Governance (PM) has met with CDIO (DR) and agreed that this will be tabled at Informal Exec Team agenda for 15 May or 29 th May 24 | Proposed to close this action but to update the Committee at the July Audit Committee in July 2024 | |
| Actions from 16th November 2023 | | | | | | |
| 3. | Associate Director of Governance | The robustness of issues in relation to breaches of late publications to be reviewed by Head of Corporate Affairs taking into account Internal Audit's last report on breaches to work on strengthening the process. | Jan 2024 | Breach paper produced for AC and process is being monitored for robustness. 29.02.24 Item remains on the agenda until stronger assurances are provided to the Committee. 05.03.24 The intervention orders issued to BCUHB upon entering into Special Measures did give a more lenient transition - as per Standing Orders, so breaches to date can mainly be marked as compliant. 23.04.24 Agenda Item to be kept open (and on the Agenda for May Audit Committee)– To continue to monitor and focus on historical data in relation to learning and progression. | Item proposed for closure | |
| Actions from 12th January 2024 | | | | | | |

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| 3. | Associate Director of Governance | AC24.4.3 The Health Board Chair provided feedback around the 'Committee Vice Chair' advising that the appointment nomination would be confirmed at the next Audit Committee. | March 2024 | 23.04.24 Urtha Felda has agreed to take on the VC role. To be agreed at the Committee on 7 th May 2024. | Item to be closed if agreed | |
| 4. | Associate Director of Governance | AC24.5.4 Declarations of Interest/Gifts & Hospitality Implementation Plan. The Acting Board Secretary would enhance future DOI updates <i>as discussed e.g. per banding declarations.</i> | As per Cycle of Business. | Verbal update to be provided at the 15 March Committee. 15.03.24 Item to be kept open – Work in progress. Update position report provided, March Agenda (Ref: AC24.40). 23.04.24 An update was provide on this at the March Committee and is reported at the May Audit Committee | Item proposed for closure | |
| 5. | Head of Risk Management | AC24.8.5 & .9 The Risk Register and Board Assurance Framework overviews are to provide more of a dashboard approach and a RAG status. | To be agreed. | Update to the action to be provided at the 15 March Committee. 15.03.24 Item to be kept open – Work in progress. It was reported that the Risk Register and Board Assurance Framework had been developed with support of the Chief Executive Officer and the Head of Risk Management. Report update provided against March Agenda item; (Ref: AC24.39). 16.04.2024 Paper includes a risk dashboard to which the CEO has approved risk management commentary. Suggest for closure and ongoing feedback on development of papers as risk papers develop. | Item proposed for closure | |
| 6. | Deputy Director of Workforce | AC24.8 The Deputy Director of Workforce agreed to review and update the risk and additional detail pertaining to the programme of activity for the Leadership Team. | March 2024 | 04/03/24 - Item complete. Revised report undergoing quality assurance by the Risk Management Team and will be submitted to the Risk Management Group and Executive Team - for scrutiny therein the onwards cycle of reporting. 15.03.24 Item to be kept open – The Risk Management Team had met with the People Services Team to progress. Item for update at May Audit Committee. 25.04.24 – Corporate risks updated with additional detail pertaining to the programme of activity for Leadership – confirmed by Head of Risk Management. | Item proposed for closure | |
| 8. | Interim Executive Director of Finance | AC24.11.5 Purchase Order breaches - the Committee Chair suggested that a deeper dive into the reasons for this be instigated. | To be agreed. | Update to the action to be provided at the 15 March Committee. 15.03.24 Item to be kept open – It was stated that the Purchase Order breaches had been raised with the area involved. It was agreed to provide an update position report to the Audit Committee in May. It was noted that purchase order breaches would also be covered in the contract and procurement audit in Q3. Propose to close as report has now been developed and is on agenda at May Committee | Item proposed for closure | |
| 11. | Interim Executive Director of Fianance | AC24.16.1 & 2 – Lessons Learnt 'Make it safe reviews' system. The Interim Executive Director of Finance suggested the development be sighted in the | March 2024 | Update to the action to be provided at the 15 March Committee. 15.03.24 Item to be kept open – The development of the "make it safe reviews" system was yet to be sighted at | Propose alignment to Action 2 on 15 March meeting. | |

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| | | Executive Team Meeting and that QSE has sight of the quality of the system. | | Executive Team Meeting, with onwards progression to the Quality, Safety Experience Committee. 05.03.24 Minor amendment to reflect EDOF agreement to propose alignment to Action 2 | | |
| 14. | Associate Director of Governance | AC24.20.1 The Acting Board Secretary to work with the Committee Chair, Interim Executive Director of Finance, Chief Executive and Internal Audit on progress relating to the Audit Tracker report, to provide assurances in future AC. | March 2024 | 05.03.24 There has been some significant work on this including the review of approach at the Executive Team Meeting following the last AC. A meeting is being arranged between the Executive Director of Operations and Audit Chair. A process developed <i>with IA agreement</i> on how to check completion. 04.03.24 IA report produced on closed recommendations to follow at May 2024 AC. 15.03.24 Item to be kept open – Significant work had been noted the recent Executive Team Meeting. It was raised that an Internal Audit Report was produced on closed recommendations and the report would be provided at the AC in May 2024. | 23.4.23 The audit committee will receive a report on this in May – Proposed to keep open until received and considered | |
| Actions from 15th March 2024 | | | | | | |
| 2. | Deputy Executive Director of Nursing | AC24.39.8 The Committee discussed the repository of learning. It was agreed to share the paper. | May 2024 | 23.04.24 Associate Director of Governance contacted Deputy Exec Dire of Nursing to check complete. 26.04.24 Feedback received via Deputy Director of Quality. The specification and “wireframe” for the app has been designed and a prototype is in place. The next and current phase is to begin testing the app, which will be done with the MHLD Division. This user testing will help further refine the app through identifying any bugs or technical issues and inform enhancements from practical use by front line clinicians, prior to wider roll-out. This testing will take place over the coming quarter. | | |
| 3. | Head of Risk Mangement | AC24.39.9 Corporate Risk Register item ref CRR24-05 – Financial Planning - The Head of Risk Management to review Line of defense | May 2024 | 16.04.24 Line of Defence updated - Completed but following comments at Management Group and Executive Team - this risk will be updated to reflect the 24/25 financial plans. | Item proposed for closure | |
| 4. | Associate Director of Governance | AC24.40.1.1 Details of Breaches to Publication of Board and Committee Papers; it was agreed to provide a visual graph in future reports also for the information be provided on a cumulative basis. | May 2024 | May Agenda item. | Item proposed for closure | |
| 5. | Associate Director of Governance | AC24.40.1.2 The Acting Board Secretary presented the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control | March 2024 | 21.04.24 - Action Complete. Item now published to BetsiNet; Management of Policies, Procedures & other Written Control Documents (sharepoint.com) | Item proposed for closure. | |

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| | | Documents, it was agreed to approve the document, subject to minor updates to Job Titles. | | | | |
| 6. | Associate Director of Governance | AC24.40.1.5 Review of Gifts & Hospitality and Declarations of interest Registers - a full report would be reported back to the Audit Committee in May. | May 2024 | May Agenda item. Proposed for closure as this duplicates a previous action. Paper has been prepared and on May agenda | Item proposed for closure | |
| 7. | Associate Director of Governance | AC24.40.1.8 Reminder to be issued to staff to update their declarations of interests. | May 2024 | This action is complete. Reminders sent through briefing and automated messages on the Declare system | Item proposed for closure | |
| 8. | Interim Finance Executive | AC24.43.6 To feedback to committee in relation to the levels of exposure costs, in terms of Welsh Risk Pool payments. | May 2024 | 03.05.24 Update to be provided at the meeting | Item proposed for closure | |
| 9. | Associate Director of Governance /Chair | AC24.44.1.3 Chair to agree on Cycle of Business; Local Counter Fraud, Bribery and Corruption Policy for the Health Board - was due for review in August 2024. It was agreed to initially review and consider the policy at a future Audit Committee. | To be agreed – future agenda item. | 23.04.24 ADOG emailed Chair and Cttee lead on 23 April to proposed September AC | Item proposed for closure | |
| 10. | Head of Risk Management | AC24.45.3 Internal Audit Reports; The Head of Risk Management agreed to provide estates risks to Internal Audit colleagues. | May 2024 | 22.04.24 IA have risk reports they require. | Item suggested for Closure | |
| 11. | Head of Risk Management/Deputy Medical Director | AC24.45.4 Internal Audit - Clinical audit plan subject to a follow up review of the recent limited assurance report. The requirement to refresh the risk and update the Committee therein the October to March 2025 plan. | May 2024 | 22.04.24 Meeting with Head of Risk and Head Of Clinical Effectiveness plan Draft proposal approved at QDG 07.04.24 Tier 1 audits progressing and escalated concerns on 4 around resources up to Strategic Clinical Effectiveness Group and back to IHCs for actioning. Head of Risk requested Tier 2 audits for review and Draft strategy. | Item suggested for Closure | |
| 12. | Interim Finance Executive | AC24.45.9 Regarding the Limited Assurance IA water safety report and responsibilities of areas; The Acting Executive Director of Finance agreed to gain further insight into the area responsibilities and risk sharing between Facilities staff. | May 2024 | 03.05.24 The Estates provision of maintenance for areas was clarified as complete by internal audit, Nursing teams completion of water safety checks (flushing in low use areas) clear within action plan for rectification of key concerns. Then I would move this to complete and green | Item proposed for closure | |
| 13. | Associate Director of Governance | AC24.45.12 The current Health & Safety Policy is overdue for review. It was agreed to follow up the urgency to update the out of date Policy. | May 2024 | 23.04.24 Head of H&S contacted on 23.4.24 Note action owner is Assistant Director of Occupational Health and Safety. Update as follows - The responsible officer agreed an extension on this for 6 months (that lasts until June 2024). This will enable the new Exec responsibilities to be defined, as the policy has to be rewritten as the accountabilities are changing. The version is drafted ready for confirmation of accountabilities. | Keep open | |
| 14. | Associate Director of Governance | AC24.45.14 The issue of non, or lack of compliance in responses to audits was highlighted. The Acting | May 2024 | This matter was tabled at Exec Team meeting when the monthly Internal Audit update was tabled. The Exec Team noted and received the report and this is a focus area for Exec Directors. An update on the process for | Item proposed for closure | |

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| | | Board Secretary agreed to raise the issue at the Executive Team Meeting. | | reporting to Audit Reports has been developed and included in the Audit Tracker update | | |
| 15. | Head of Risk Management Head of Covid Inquiry | AC24.46.2 Overdue audit recommendations. A log of the recommendations for closure <i>signed off by Internal Audit</i> would form part of the future reporting. AC24.46.3 It was agreed to correct an error, as pointed out by the Chair, within the statistics therein the report. | May 2024 | 18.04.24 Update for May AC – an update on the current position with all recommendations will be provided for the May AC, which will include a log of recommendations that are awaiting approval at the different stages of the approval process. | 23.4.23 The audit committee will receive a report on this in May – Proposed to keep open until received and considered | |
| 16. | IHC Director West Head of the Covid Inquiry | AC24.46.5.3 Updated ownership (to be agreed) of the GP out of hours recommendations. IHC Director and GD to confirm and update the Tracker details. | May 2024 | 18.04.24 Update for May AC - All outstanding recommendations for this Audit Report are proposed for closure, therefore if approved, this work will be concluded. | Item proposed for closure | |
| 17. | IHC Director West | AC24.46.5.4 It was agreed to invite the Head of Risk Management and the Head of the Covid Inquiry to the Operational Leadership Team Meeting to instigate updates to outstanding actions | May 2024 | 16.04.24 – Update –The Head of Risk Management attended the SLT operations meeting 10.04.24 to discuss the IA tracker and requesting outstanding actions/evidence be submitted. | Item proposed for closure | |
| 18. | Head of Risk Management/ Associate Director of Governance | AC24.46.5.6 Gold, Silver and Bronze On Call - it was agreed to recirculate the internal audit report. | May 2024 | 22.04.24 Item Circulated. | Item suggested for Closure | |
| 19. | Head of Risk Management Head of Covid Inquiry | AC24.46.6 The Chair commented upon the tracker as a whole, and suggested that the Internal and External Audits be placed upon separate documents for the next financial year and it was noted that in future, the reports would be condensed and easier to manage | May 2024 | 18.04.24 Update for May AC - The internal and external audits recommendations will be reported separately at future Audit Committees | Proposed to keep this open due to the need to gain assurance in the meeting | |
| 20. | Associate Director of Governance | AC24.49.2 Board Effectiveness follow up - The Acting Board Secretary confirmed the report was be noted at the Public Health Board Meeting in March, within the Chief Executives update report. | March 2024 | 23.04.24 This report was received and considered at the Board in March 2024 | Item suggested for closure | |
| 21. | Associate Director of Governance | AC24.51.1 Items for referral to other Committees were agreed as follows: On call arrangements to be raised with the People and Culture Committee regarding recommendations to compensation / rest periods. | May 2024 | 16.04.24 - Update - Acting Board Secretary raised as a matter for cycle of business for "People and Culture" and also made relevant Exec aware to review in Workforce Groups - suggest close. | Item suggested for Closure | |
| 22. | Chair/Committee Lead | AC24.54.2 It was agreed that the agenda required review. | May 2024 | Update April 2024 – Agenda reviewed and updated following the Agenda Setting Meeting by the Director of Corporate Governance. | Item suggested for Closure | |



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| Teitl adroddiad: <i>Report title:</i> | Update report on Internal and External Audit Recommendations | | |
| Adrodd i: <i>Report to:</i> | Audit Committee | | |
| Dyddiad y Cyfarfod: <i>Date of Meeting:</i> | 7 th May 2024 | | |
| Crynodeb Gweithredol: <i>Executive Summary:</i> | <p>The purpose of this report is to provide the Audit Committee with:</p> <ul style="list-style-type: none"> • details of the proposed new process around the introduction of new External Audit Reports to the Health Board • details of the proposed new process around the introduction of new Internal Audit Reports to the Health Board • details of the proposed new process around the closure of audit recommendation • an update of the current position with regards to open recommendations, and those proposed for closure • details of all limited assurance recommendations • the list of all internal and external Audit Recommendations that have been approved by each Executive; and • an update on next steps. | | |
| Argymhellion: <i>Recommendations:</i> | <p>The Committee is asked to;</p> <ul style="list-style-type: none"> • consider the proposed new processes around the introduction of new External and Internal Audit Reports to the Health Board • consider the proposed new audit recommendation closure approval process • note the current position with regards to open recommendations, those proposed for closure, and limited assurance recommendations • agree the Audit recommendations proposed for closure to be presented to Internal Audit for review • note the current position of overdue audit recommendations • approve for closure the recommendations from January which do not fall within the Audit Charter for Internal Audit approval; and • take assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations. | | |
| Arweinydd Gweithredol: <i>Executive Lead:</i> | Pam Wenger, Director of Corporate Governance | | |
| Awdur yr Adroddiad: <i>Report Author:</i> | Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry | | |
| Pwrpas yr adroddiad: <i>Purpose of report:</i> | <p>I'w Nodi <i>For Noting</i></p> <p><input type="checkbox"/></p> | <p>I Benderfynu arno <i>For Decision</i></p> <p><input checked="" type="checkbox"/></p> | <p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p> |

| Lefel sicrwydd: Assurance level: | Arwyddocaol Significant <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | Derbyniol Acceptable <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | Rhannol Partial <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i> |
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| 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: | | | | |
| <p>Even though a considerable amount of work has taken place since the last Audit Committee on 15th March 2024 to ensure that all open recommendations are updated with realistic implementation dates, a number of overdue recommendations remain open, with many of these being of 'high' priority. However, since the last Audit Committee, a new proposed approval process for closed recommendations was put in place, which means that all recommendations proposed for closure are to be agreed by each individual Executive, and thereafter the Executive Management Team prior to submission, with evidence to support closure to Internal Audit. Due to this, there will no longer be recommendations for closure submitted from the Corporate Governance Directorate (formerly the Office of the Board Secretary), but rather from Internal Audit following their review. As usual guidance and support is provided by the Corporate Governance Directorate to all recommendation action owners and Executive Leads.</p> | | | | |
| Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s): | Not applicable, other than those relating to individual audit reviews/recommendations. | | | |
| Goblygiadau rheoleiddio a lleol: Regulatory and legal implications: | Compliance with Internal and External Audit requirements. | | | |
| 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 report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups | | | |
| 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, and 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) | Not applicable, 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 | Not applicable, other than those relating to individual audit reviews/recommendations. | | | |

| | |
|---|--|
| <p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p> | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p> |
| <p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p> | <p>The Chair of Audit Committee met with the Interim Executive Director of Operations prior to her departure to gain further assurance on those recommendations where no update has been received.</p> |
| <p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p> | <p>Not applicable, other than those relating to individual audit reviews/recommendations.</p> |
| <p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p> | |
| <p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>Implementation of recommendations</i></p> <p>The Tracker is normally presented to each quarterly meeting of the Audit Committee, but is presented at every bi-monthly meeting at present due to partial assurance. The Corporate Governance Directorate continues to provide support and advice for recommendation owners and final approvers/Executive leads.</p> | |
| <p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i></p> <ul style="list-style-type: none"> • Appendix 1 – Audit tracker with recommendations closed at January Audit Committee • Appendix 2 – Draft Internal Audit report on January closed recommendations • Appendix 3 – Recommendations that will not be reviewed by Internal Audit • Appendix 4 – January recommendations approved for closure by Internal Audit • Appendix 5 – Final Internal Audit report on January closed recommendations • Appendix 6 – January recommendations awaiting Internal Audit approval • Appendix 7 – Audit tracker with all recommendations in March • Appendix 8 – List of Audit Recommendations proposed for closure at March Audit Committee | |

1. INTRODUCTION AND BACKGROUND

This report provides an update on the current state of all Internal and External Audit Recommendations that remain open following the last Audit Committee meeting on 15th March 2024, and provides an update on all recommendations that have been put forward for closure at Audit Committees since January 2024, as well as the position following the latest updates on progress at the beginning of April.

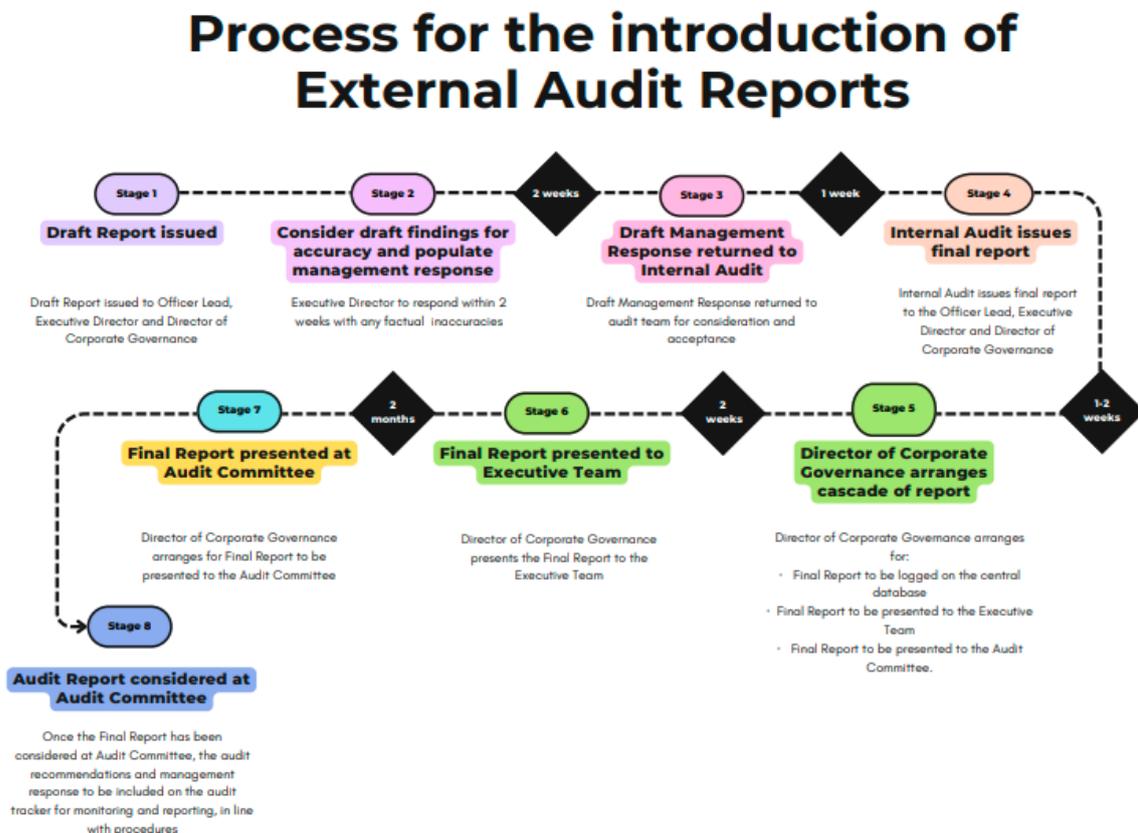
Also included in this report is the proposed process for the introduction of new Audit Report to the Health Board, as well as the proposed approval process for the closure of Internal and External Audit Recommendations.

2. APPROVAL PROCESSES

The Director of Corporate Governance has been reviewing the processes around External and Internal Audits, and once the proposed processes are approved by the Executive Team, these will be developed and brought through to the next Audit Committee meeting for approval.

2.1 Introduction of External Audit Reports to the Health Board

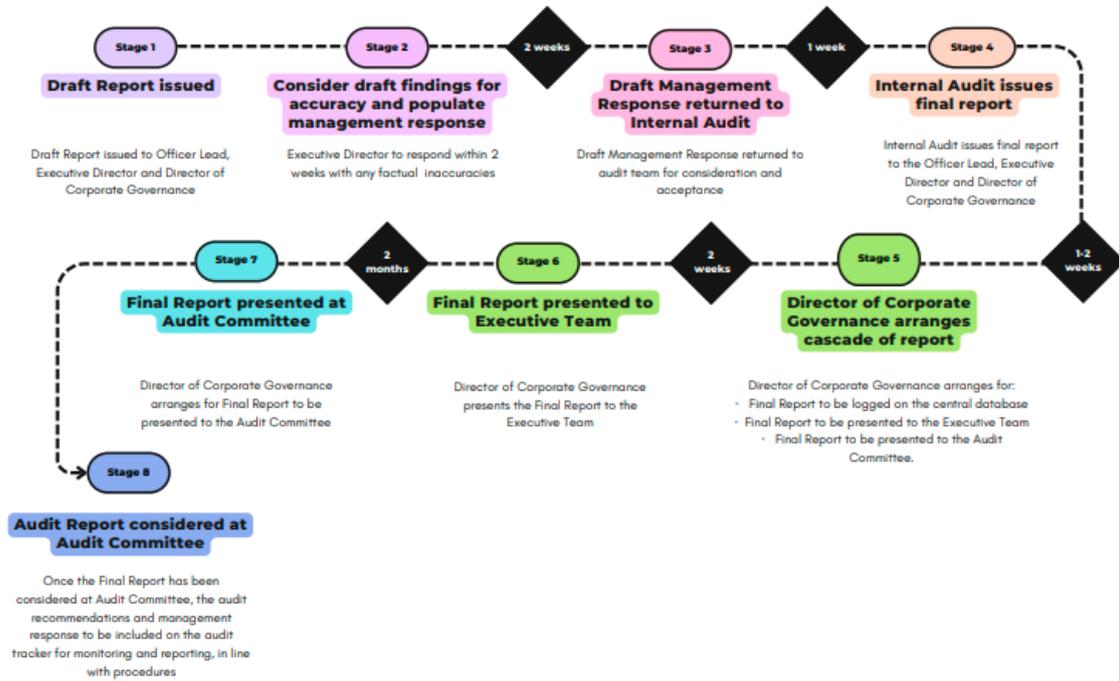
The process around the introduction of External Audit Reports is proposed as follows:



2.2 Introduction of Internal Audit Reports to the Health Board

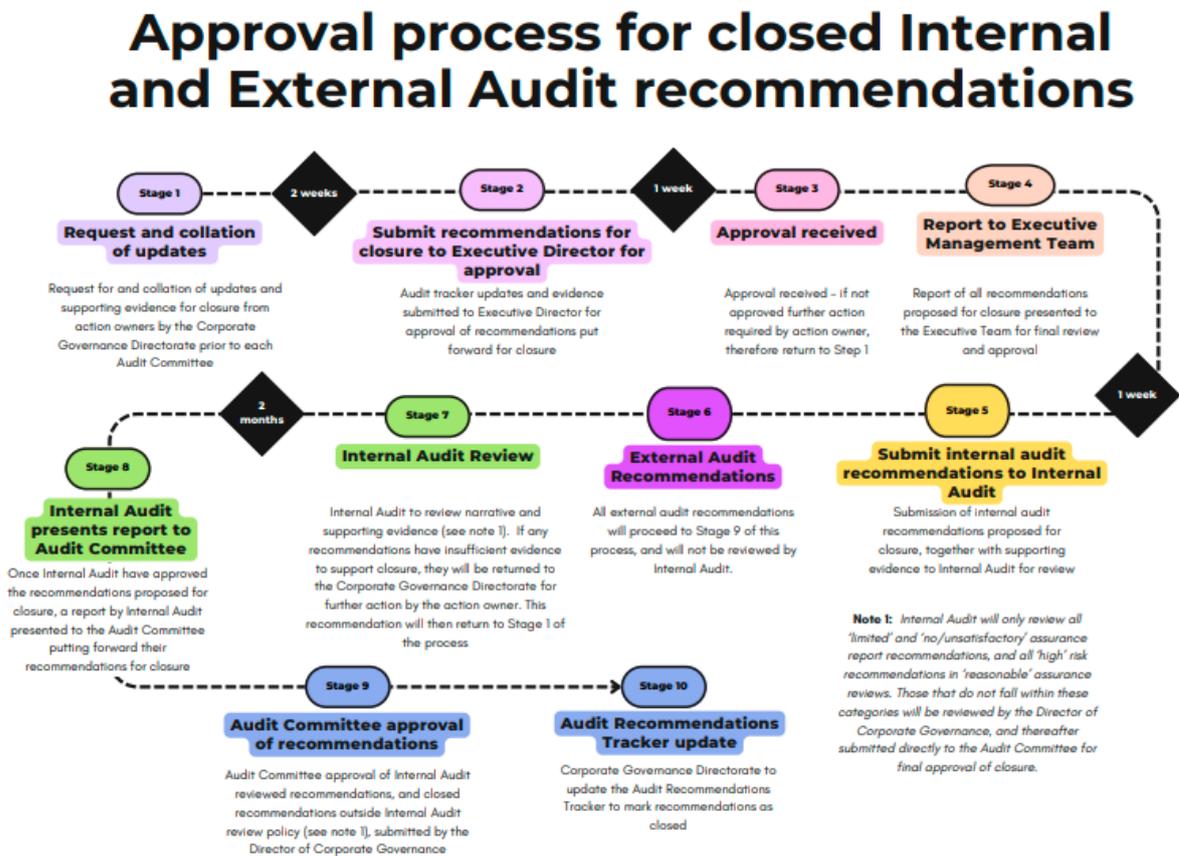
The process around the introduction of Internal Audit Reports is proposed as follows:

Process for the introduction of Internal Audit Reports



2.3 Approval of closed Internal and External Audit Recommendations

The process around the approval of all External and Internal Audit Recommendations for closure is proposed as follows:



3 CURRENT POSITION

3.1 Progress since January Audit Committee

At the January 2024 Audit Committee, it was reported that a total of 151 internal and external audit recommendations listed on the audit tracker, some dating back to Audit Reports from 2017. A total of 49 recommendations were put forward and approved for closure pending Internal Audit review at that meeting. A copy of the tracker showing these 49 recommendation is included in Appendix 1. The updates and additional evidence to support closure of these recommendations were submitted via the Teams channel to Internal Audit on 16th January 2024.

Following this, Internal Audit produced a draft report on 29th February 2024, which showed those that had been approved for closure. See Appendix 2 for copy of draft report.

As per the Audit Charter, Audit and Assurance are required to follow up:

- all recommendations (High/Medium/Low) from Limited/No/Unsatisfactory assurance rated reports; and
- high recommendations from other reports (Substantial or Reasonable assurance rated reports).

Due to this, a total of 31 recommendations would be reviewed in line with the Audit Charter, as follows:

| Type of action | Number of recommendations |
|---|---------------------------|
| 'High'/'Medium'/'Low' priority recommendations from 'Limited' reviews | 24 |
| 'High' priority actions from 'Reasonable' reviews | 7 |

A total of 18 recommendations would therefore not be reviewed by Internal Audit, and a copy of the tracker with these recommendations is included in Appendix 3. The Audit Committee is asked to provide its final approval that these remaining 18 recommendations can be formally closed.

Of the 31 actions reviewed, Internal Audit considered:

- 17 to be closed, with evidence to verify completion;
- 6 to be partially closed, with limited evidence to verify completion; and
- 8 to remain outstanding, with no or limited evidence to support closure.

A copy of the tracker showing the 17 Internal Audit-approved closed recommendations is at Appendix 4.

For those partially closed and outstanding recommendations, the Corporate Governance Directorate worked with the action owners and Executives to source the evidence required, and this was submitted to Internal Audit via the Teams channel on 14th March 2024.

A final Follow-up report was submitted by Internal Audit on 26th March 2024, and a copy is included in Appendix 5. A response from Internal Audit in relation to the evidence submitted is awaited. A copy of the tracker with the recommendations awaiting Internal Audit review is included in Appendix 6.

3.2 Progress since March Audit Committee

At the March 2024 Audit Committee, it was reported that there were 114 internal and external recommendations listed on the audit tracker – see Appendix 7. Please note that this 114 does not include the 49 recommendations awaiting approval for closure from the January 2024 Audit Committee – again, these are currently listed as 'open – pending closure approval'. Of these 114, 50 were put forward for closure – see Appendix 8. Due to the ongoing discussions around the introduction of new closure approval process, these 50 recommendations were not approved for closure.

3.3 New Audit Reports added to tracker

Since the March Audit Committee, the recommendations from two audit reports have been added to the audit tracker, as follows:

- Follow-up: Delivery of Health Board savings – 5 new recommendations
- Water Safety – 12 new recommendations.

3.4 April recommendation updates

As part of the April recommendation updates, a further 33 recommendations were put forward for closure. In addition to this, there was an omission of one recommendation (reference 245) for closure to the January Audit Committee, therefore this is now included.

3.5 Introduction of new recommendation closure approval process

Each of these 34 recommendations, as well as the 50 recommendations presented to the March Audit Committee are now subject to the new proposed approval process (subject to its formal approval), and have all be submitted to each individual Executive for review and approval prior to submission to the Executive Management Team.

Prior to the Formal Executive Team meeting on 24th April 2024, the Executives were provided with a copy of all their recommendations put forward for closure, and all recommendations were approved for closure - these can now be submitted to Internal Audit, together with the supporting evidence for their review.

The current situation with Executive approvals is as follows:

| Executive Lead | Approved for closure by Exec | Awaiting approval by Executive |
|---|------------------------------|--------------------------------|
| Executive Director of Operations, now re-assigned to others | 0 | 28 |
| Executive Director of Nursing and Midwifery | 17 | 0 |
| Executive Director of Transformation and Strategic Planning | 4 | 0 |
| Deputy Director of People | 3 | 0 |
| Director of Corporate Governance | 16 | 0 |
| Interim Executive Director of Finance | 12 | 0 |
| HB Lead for MHLD and Welsh Language | 4 | 0 |
| Total | 56 | 28 |

Please note that, due to the temporary transfer of responsibilities following the departure of the Interim Executive Director of Operations, the Executives need more time to familiarise themselves with the Audit Report and recommendations in order to be able to review and therefore approve some of the recommendations proposed for closure. Any that are not approved will be submitted to a future Executive Team meeting.

4 SUMMARY OF ALL ASSURANCE RECOMMENDATIONS

Below is a summary of all 'limited' assurance recommendations, and their status:

| Executive Lead | 'Limited' Assurance recs - open | 'Limited' Assurance overdue recs - started | 'Limited' Assurance overdue recs - pending | Limited Assurance recs open and overdue original implementation date | 'Limited' Assurance recs - for closure |
|---|---------------------------------|--|--|--|--|
| Executive Director of Operations, now assigned to others | 4 | 4 | - | 4 | - |
| Executive Director of Nursing and Midwifery | 15 | 10 | 5 | 15 | 32 |
| Executive Director of Transformation and Strategic Planning | - | - | - | - | 2 |
| Deputy Director of People | 4 | 4 | - | 4 | - |
| Director of Corporate Governance | - | - | - | - | 21 |
| Interim Executive Director of Finance | 14 | 14 | - | 10 | 13 |
| HB Lead for MHL D and Welsh Language | - | - | - | - | 4 |
| Total | 37 | 32 | 5 | 33 | 72 |

Below is a summary, by Executive, of all 'reasonable' assurance recommendations, and their status:

| Executive Lead | 'Reasonable' Assurance Recs open | Reasonable Assurance recs open and overdue original implementation date | 'Reasonable' Assurance Recs for closure |
|---|----------------------------------|---|---|
| Executive Director of Operations, now assigned to others | 1 | - | - |
| Executive Director of Nursing and Midwifery | 2 | - | - |
| Executive Director of Transformation and Strategic Planning | 1 | 1 | - |
| Interim Director MHL D | 2 | 2 | - |
| Deputy Director of People | 1 | 1 | 1 |
| Director of Corporate Governance | - | - | 5 |
| Interim Executive Director of Finance | 1 | 1 | 1 |
| HB Lead for MHL D and Welsh Language | 3 | 3 | 2 |
| Total | 11 | 8 | 9 |

Below is a summary of all 'n/a' assurance recommendations, and their status:

| Executive Lead | 'n/a' Assurance recs - open | n/a Assurance recs open and overdue original implementation date - open | 'n/a' Assurance recs - for closure |
|---|-----------------------------|---|------------------------------------|
| Executive Director of Operations, now assigned to others | 1 | 1 | - |
| Executive Director of Transformation and Strategic Planning | 2 | - | 2 |
| Director of Corporate Governance | - | - | 1 |
| Total | 3 | 1 | 3 |

5 **AUDIT TRACKER**

As has been previously reported, the Corporate Governance Directorate has been working with the Digital, Data and Technology (DDaT) team to create a bespoke audit tracker for the Health Board. However, due to the delay in this work being progressed, research around other available options has been undertaken, and the CGD has a number of upcoming demonstration over the coming weeks. An update on progress in this respect will be provided at the next Audit Committee.

6 **IN SUMMARY**

Of the 49 recommendations approved for closure at the January Audit Committee:

- 31 recommendations were reviewed by Internal Audit, and of these:
 - 17 were approved by closure
 - 6 were partially closed, and further evidence to support closure has been submitted by the Health Board – awaiting final Internal Audit Review
 - 8 remained outstanding, and further evidence to support closure has been submitted by the Health Board – awaiting final Internal Audit Review
- 18 will not be reviewed as they do not fall within in line with the Audit Charter, and will be approved for closure by the Director of Corporate Governance.

Of the 50 recommendations put forward for closure at the March 2024, but were not approved, and the 33 further closed recommendations from April, and the 1 recommendation that should be been submitted to the January Audit Committee:

- 84 recommendations have been submitted to the Executives to approve their respective closures, of these:
 - 44 have been approved, and have been submitted to the Executive Management Team for final approval
 - 40 remain outstanding for review, and those approved submitted to the next Executive Management Team for approval
- Once approved, the updates and evidence to support closure will be submitted to Internal Audit for their review
- Any that are not approved for closure by the Executives will be returned for further work by the action owner
- Once reviewed, Internal Audit will provide an update on the recommendations proposed for closure to the Audit Committee for final approval.

If the new proposed approval process, which is currently being consulted upon is implemented, there will not be any recommendations submitted for closure approval at the May Audit Committee. In future, recommendations put forward for closure will be presented by Internal Audit following their review of the updates and supporting evidence.

Finally, a total of 133 internal and external audit recommendations have been put forward for closure since January 2024, and if these are closed, a total of 51 recommendations remain open on the tracker, with 21 new recommendations added since the March Audit Committee. A considerable amount of work has taken place since January 2024, but there is much more to be done over the coming weeks and months to be able to provide the Audit Committee with the assurance it requires.

APPENDIX 1 – AUDIT TRACKER WITH RECOMMENDATIONS CLOSED AT JANUARY AUDIT COMMITTEE

APPENDIX 2 – DRAFT INTERNAL AUDIT REPORT ON JANUARY CLOSED RECOMMENDATIONS

APPENDIX 3 – RECOMMENDATIONS THAT WILL NOT BE REVIEWED BY INTERNAL AUDIT

APPENDIX 4 – JANUARY RECOMMENDATIONS APPROVED FOR CLOSURE BY INTERNAL AUDIT

APPENDIX 5 – FINAL INTERNAL AUDIT REPORT ON JANUARY CLOSED RECOMMENDATIONS

APPENDIX 6 – JANUARY RECOMMENDATIONS AWAITING INTERNAL AUDIT APPROVAL

APPENDIX 7 – AUDIT TRACKER WITH ALL RECOMMENDATIONS IN MARCH

APPENDIX 8 – LIST OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE AT MARCH AUDIT COMMITTEE

AUDIT COMMITTEE

INTERNAL AUDIT TRACKER

| ID | Committee | Internal Audit (IA)/ Wales Audit Office (WAO) | Report Title | Year | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Last status updates (September and October) | Latest status update | Action Owner | Final Approver | Recommendation State | Original implementation date | Revised implementation date | Number of Revisions | Actual Implementation Date | Date Final approved | For closure consideration at next Audit Committee? | Date Audit Committee approved closure | | |
|-----|------------------|---|--|------|-----------------|----------|---|---|--|---|---|--|--|-----------------------|------------------------------|-----------------------------|---------------------|----------------------------|---------------------|--|---------------------------------------|-----|--|
| 59 | Audit Committee | Internal Audit | Risk Management | 2022 | Reasonable | Medium | Strategic Objectives | The Health Board revisits its strategic priorities, setting objectives that are measurable by a set timeline. Further review of its completion to ensure aspects identified within the findings around risk appetite/target risk and controls etc. | The BAF continues to evolve with the engagement and support of the full Board. With the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' and all underpinning strategies, the Board will need to ensure a greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. This will be undertaken during the course of the year, ensuring that clearly articulated and measurable objectives are set, for achievement within a specific timeline. A review of the risk appetite/target risk score was undertaken at a Board Workshop on 27th April and further review/refinement will continue linked to the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' as we move through the year. | Progress update required from Board Secretary and CEO - to be discussed at ET 08/11/2023. | The Executive Team and Committee members are sighted on the current version of the Board Assurance Framework which is aligned to Strategic Priorities in the Annual Plan and have taken the action to review the Health Board's Objectives. This work will start in Feb 24 and the Board Assurance Framework risks will be aligned to objectives. The Acting Board Secretary is proposing to close the action to reflect this update, but also to note that original action was 2022, and related to an earlier context, of which events have moved on. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 31/03/2022 | 30/03/2024 | 2 | | | | | Yes | |
| 72 | PFIG | Internal Audit | Performance measure reporting to the Board – Accuracy of Information | 2021 | Reasonable | Medium | Reporting Accuracy | Whilst we recognise that first issue above was likely the result of a typing error, management must ensure that all data reported is accurate. To ensure consistency and transparency, changes to reporting methodology should be noted in the report and communicated to the reader. | Information reported to the Board in the Quality and Performance (Q&P) reports is currently extracted from a number of different data sources. Narrative to support the data is a combination of analysis by the Divisional/Programme leads and Performance Team Heads of Performance and Director of Performance. The current process is labour intensive and time consuming, the time between data being available and deadlines for producing the reports/completing the necessary internal governance clearance significantly limits the ability of the Performance Team to undertake quality assurance both in relation to the accuracy of the data included in each report as well as consistency between reports over time. The Board has requested the development of a new integrated Quality and Performance Report (IQPR), this presents an opportunity to address the issues that are curtailing QA processes as well as to improve the content of the reports to ensure that the needs of the Board and subcommittees are met. Changes proposed include: Rationalising and automating the process of data collation and reporting - This will be supported by a process map of the current arrangements, which will enable the Health Board Informatics Team to develop a single performance data set. The Performance Team will work with the system developers in Informatics to harness Business Intelligence software with the aim of automating production of the 'front end' Board and Public facing reports. Once completed this new process should release Performance Team capacity to undertake detailed analysis of the information moving from performance reporting to performance monitoring and management, and should also provide more time to complete QA checks. Clear methodology for identifying areas of concern - The intention is to implement an assurance and risk scoring system that can be applied to each key metric (national and local) as well as the actions/outcomes identified in the Health Board Annual Plan. This will highlight the areas of greatest risk and/or lowest assurance which need to be brought to the attention of the Board. Additions and removals of items reported - Level of risk and assurance will change over time as a result of external factors as well as action taken by the service. The new IQPR will require a more dynamic approach to the items reported. It is recognised that the reasons for additions/removal of items from the report need to be open and transparent. It is intended that the new IQPR and the current reports, which will need to continue until the new report is in place will include a section where additions, removals and reasons for these changes are recorded. With regards to the development of the new IQPR, a Board workshop session took place on 27th April 2021 to discuss requirements. A plan comprising report specification and timescale will be produced for consideration by the CEO, Chairman and Executive Team in June 2021. | In line with the development of the IQPR, a further Board workshop has been held to explore the requirements of Committee Chairs in terms of assurance levels with reporting. As a result of these discussions, a proposed alternative dashboard has been developed which will be supported by a decision tree and supported via MS 365. This dashboard will be used to monitor performance via accountability meetings and narrative will be captured to support reporting into committees. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2021 | 31/12/2022 | 5 | | 22/08/2023 | Yes | | | | |
| 111 | People Committee | Internal Audit | Impact Assessments | 2022 | Reasonable | Medium | Policies and Procedures | 1.1a Health Board to clarify and document requirements regarding other Impact Assessments, and ensure information is embedded or signposted in key Health Board policy documentation (e.g. QBS1 Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, and F017 Policy for Revenue Business Case Development), and is accessible and visible to staff developing proposals / policies. Consideration should be given to an intranet page with the relevant resources and expertise signposted for staff. 1.1b Health Board to consider progressing and developing the Impact Assessment Gateway document for strategic and policy decisions including written control documents and development proposals to ensure statutory requirements are met. | The Office of the Board Secretary will review, develop and implement the Impact Assessment Screening Tool (IAST) in consultation with colleagues in strategy and planning, Equalities and other supporting functions. This review will take account of proportionality, recognising that some Impact Assessments are mandatory, some are of a technical nature (e.g. environmental impact assessments) and some are best practice. The review will also consider impact assessments that may become mandatory in the near future, such as the Health Impact Assessment, as well as being mindful of the principles of sustainable development contained within the Wellbeing of Future Generations Act. The review will also be further informed by the report of the Audit Wales review of Equality Impact Assessments across the Welsh public sector which commenced in October 2021 and for which the report is due in summer 2022. Once complete, associated key policies/documentation (Policy on Policies, Policy for Revenue Business Case Development etc.) will be updated to link back to the tool. The IAST will be uploaded to the Health Board's Policies and Procedures page on the staff intranet and can be linked back to from other key sites. The document will be subject to Health Board wide consultation (via the corporate bulletin, 'Draft documents for consultation intranet page' and targeted comms) and signed off by the Executive team. | The integrated Assessment Screening Tool has been drafted in conjunction with relevant stakeholders/ corporate leads i.e. Equality Team, Welsh Language Team, Children's Services, Older Persons/Lead Nurse for Dementia, Safeguarding, Carers, Patient Experience, Finance and Transformation and Improvement Colleagues. The document is pending final review and comments with the Safeguarding Team and will then be sent on to Executives for final sign-off as per the Health Board's Policy on Policies. Following consideration the assessment is that a stand-alone intranet page is not necessary and would risk further confusion. Instead the IAST will be included on existing Equality/Policy/Business Planning intranet pages. | Ceri Harris, Head of Equality and Diversity | Jason Brannan, Deputy Director of People | Final Client approved | 31/10/2022 | 31/03/2024 | 2 | 13/02/2023 | 30/08/2023 | Yes | | | | |
| 119 | Audit Committee | Internal Audit | Integrated Service Boards (ISB) | 2022 | Limited | High | 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. | 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 | 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. October update - The revised Scheme of Delegation, together with the Risk Management Framework have been completed and were signed off Sept 23. The revised Committee Framework will be presented to the November Audit Committee. Performance and Planning Frameworks were also approved. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/06/2022 | 30/09/2023 | 4 | | 25/10/2023 | Yes | | | | |
| 120 | PFIG | Internal Audit | Budgetary Control and Financial Reporting, including COVID-19 financial governance | 2021 | Reasonable | Medium | Authorised Virements | Finance to ensure that effective manual processes are in place to ensure segregation of duties are being adhered to, including regular sampling of virements. | 1) E-mail the Divisional Finance Teams to remind them of the importance of following due processes, with the process notes attached for information. (This action has already been carried out). 2) Sample 10% of virements on a month basis to test segregation of duties and authorisation of virements, calling CFO to account for any Breaches within their team. | Sampling of 10% of virements has been built into the regular monthly workflow processes, which incorporates calling CFOs to account for any breaches within their team. | Additional assurance and evidence provided for closure on sampling. | Michelle Jones, Head of Financial Reporting | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 25/06/2022 | | 0 | 08/06/2022 | 22/08/2023 | Yes | | | |
| 121 | PFIG | Internal Audit | Budgetary Control and Financial Reporting, including COVID-19 financial governance | 2021 | Reasonable | Low | Questionnaire responses | Finance to review the findings of the audit questionnaire, and complete the planned rollout of divisional questionnaires commencing March 2022. | 1) Finance to review the findings of the audit questionnaire and take on board any feedback. 2) Process for Divisional questionnaires to be sent out March 2022 onwards. This to be via a rolling process of 2 Divisions per month with a sample of 10-20 budget holders per Division. Feedback will be considered and steps taken to address any necessary actions which arise. (Questionnaires have been sent to a sample of budget holders in MH&LD & NWH Division in March and responses are currently being received and co-ordinated). | Questionnaire responses from the Audit questionnaires and the Finance questionnaires, where these have been received, have been reviewed. As further responses are received these reviews will continue, and if necessary action plans to address any recurring themes will be drawn up. | Questionnaire feedback supplied for additional assurance and evidence provided for closure | Michelle Jones, Head of Financial Reporting | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 24/06/2022 | | 0 | 08/06/2022 | 22/08/2023 | Yes | | | |
| 127 | QSE | Internal Audit | Clinical Audit | 2022 | Limited | Medium | Policy and process in place for clinical audit. | Review and update the policy and procedure document MD22, and include the governance structure within Appendix 1. | Management comment: Awaiting release of final operating model. The updated policy has been held in draft form, since September 2021, awaiting confirmation of the new organisation operating model and associated governance structures. The governance that underpins the new operating model, directly impacts on the roles and responsibilities embedded within the policy as well as providing necessary operational detail (included within the appendices). Agreed action - Subject to confirmation of the new operating model (and governance structure) in April 2022, the audit policy will be released for Health Board wide consultation May 2022, with view to agreement through Clinical Policies and Procedures Group (CPPG) / Clinical Effectiveness Group (CEG)/ Quality, Safety and Clinical Effectiveness (QSE) by September to accommodate Cycle of Business of these groups. The reviewed policy will outline all processes and current practice in relation to clinical audit activity within BCUHB and will reinforce its role within the quality framework in delivering quality improvement and quality control and will be formally communicated to staff. | The policy was approved at EDG (Quality) meeting. The remainder of the process to upload onto the Policies page on the intranet, and link to our Clinical Effectiveness webpage, and for the team to disseminate to local CEGs will now be implemented. October update - As referenced in Internal Audit report from October 2023 : 2.1 The Clinical Audit Policy and Procedure is available on the Health Board intranet site (BetsiNet). The QSE committee approved the latest version on 20 June 2023, and this was uploaded to BetsiNet on 6th July 2023. The document outlines the procedure for conducting clinical audits, including those required by the Welsh Government (Tier 1). | The Clinical Audit Policy has now been completed and ratified and uploaded on to the intranet after going through the relevant processes. The policy is disseminated to local CEGs and promoted by the team each month in Local CEG meetings. We will be adopting of sharing direct to the IHC MDs on a monthly basis copying in HoFCE and DEMD. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2022 | 30/04/2023 | 5 | 20/04/2023 | 08/08/2023 | Yes | | | |

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|-----|------------------|----------------|---|------|-------------|--------|--|---|--|---|---|---|--|-----------------------|------------|------------|---|------------|------------|-----|--|
| 165 | PFIG | Internal Audit | Waste Management | 2022 | Reasonable | Medium | Non-compliance with Covid-19 operating procedure | Recommendations agreed to increase compliance with the Covid-19 SOP should be progressed and reviewed regularly to ensure implementation. | Estates and Facilities will continue with support from Senior Infection Prevention Leads, to increase compliance with the Covid-19 Standard Operating Procedure which will be reported through Infection Prevention Sub-Group. | Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August. Compliance with the COVID19 SOP has now been achieved with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE. | Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August. Compliance with the COVID19 SOP has now been achieved with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE. November update: Meetings have now been held with the IHC's and areas with plans put in place and waste audit's carried out on three sites including central IHC, Mold and Bryn Beryl. Additional evidence of closure provided. | Richard Daniel, Interim Director Capital and Estates | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/08/2022 | | 0 | 20/09/2022 | 22/08/2023 | Yes | |
| 167 | People Committee | Internal Audit | Speak out Safely | 2022 | Reasonable | Medium | MDT Process log | 1.1a Dates to be added into progress log i.e. 'date recorded' 'date of review' to enable tracking of concerns to outcomes. 1.1b Attendance at MDT meetings to be recorded to demonstrate meetings are quorate. | 1.1a To add in details of recommendations in 1.1a into the MDT process log (process log updated and provided for reference). 1.1b Full names of attendees at MDT meetings will be captured on the process log (process log updated and provided for reference) | MDT process log has been updated as per recommendations and reviewed by Osama Lofly from the Audit Team and signed off as meeting the required standard. Action completed. | A record of the 'date recorded' and 'date of review' and also that attendance at meetings are logged. Additional evidence of closure provided. | Gareth Evans, Senior Organisational Development Manager | Jason Brannan, Deputy Director of People | Final Client approved | 30/11/2022 | | 0 | 12/12/2022 | 30/08/2023 | Yes | |
| 170 | QSE | Internal Audit | Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfenau ar y We/fenary Documents on the Website | 2022 | Limited | High | 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 the English website. | 2.1a In response to recommendations 1.1, 1.2 and 1.3 recommendations have been made to resolve the current risk of non-compliance. These include: Establish a formal policy and guidance to support the management of BCU digital channels, including the website. Review current administration access to the BCU website and issue revised guidance and training where required. Recruit a dedicated translator for the Corporate Communications Team to manage all translation requests for the website, which will ensure content is published simultaneously and ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. 2.1b Issues identified with the audited web pages that are managed by the Corporate Communications Team have been resolved. 2.1b Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website. 2.1b Establish a regular programme of audits with the Welsh Language Team to monitor the website on a monthly basis. 2.1b The Board Secretary to review and resolve issues relating to the publication of inconsistent Board/Committee papers and bundles. | 1. Controls implemented include: a. BCUHB Website and Social Media Content Management Protocol; b. List of editors reviewed/refreshed and subject to periodic review; c. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). 2. Outstanding action relates to reviewing existing historical content. External support has been commissioned, review underway, expected completion date end of September. October update - a. BCUHB Website and Social Media Content Management Protocol - Activated and implemented 10th August 2023 Policies and Written Control Documents - COM 01 - BCUHB Website and Social Media Content Protocol.pdf - All Documents (sharepoint.com); b. List of editors reviewed/refreshed and subject to periodic review - Editor listing reviewed and updated, work is ongoing to monitor periodically - August 2023; c. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). Regular audits are planned and are conducted. 2. Outstanding action relates to reviewing existing historical content. External support has been commissioned, review underway, expected completion date end of September. | The support from the external company is now complete, and this concludes the actions relating to this recommendation. The draft report has been received back from the Auditors to confirm all actions have been completed and no further actions is required. This recommendation can now be closed. | Andrew Rogers, Head of Corporate Communications | Teresa Owen, Executive Director of Public Health | Final Client approved | 31/12/2022 | 30/09/2023 | 3 | | | Yes | |
| 189 | Audit Committee | Internal Audit | Chairs action | 2022 | Reasonable | Medium | Information provided to members / committees | All Board/Committee members should have access to the information provided with the request to ensure transparency and further scrutiny. | Investigate a SharePoint site for Chair's Actions which will enable all Chair's Actions to be reviewed by all IMs should they wish to do so. | Recommendation has been delayed due to OBS staffing issues and board member changes. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The reason why this has been marked as complete is that the corporate governance report now contains a routine capture of all Chair's Actions. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | Final Client approved | 31/01/2023 | 29/02/2024 | 1 | | | Yes | |
| 193 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | High | 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. | 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 their role as a Board member of the Corporate Trustee. Spotlight on a Fund and Fund Advisor, so they are aware of the responsibilities and actions of those who are charged with overseeing different funds on behalf of the Corporate Trustee: Updates on grants awarded and grant impact, Review of internal and external communications. 1.2 A review of the content and frequency of information provided to Trustees will be tabled at the Charitable Funds Committee for discussion and reviewed at the Trustee meeting. | COMPLETED. Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair / Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM and Exec updates and regular communications are included on the Betsinet page. | Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair/Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM & Exec updates and regular communications are included on the Betsinet page. The info for the IMs provided for handbook: included in the 30/03/2023 Trustees meeting and the intro sent to the CEO, for example. BetsiNet information regularly updated for Trustee Board to keep abreast of developments, and additional information regarding governance now included on Charitable Funds Committee webpage - additional evidence provided. | Kirsty Thomson, Head of Fundraising :Awyr Las | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/01/2023 | | 0 | 04/05/2023 | 22/08/2023 | Yes | |
| 199 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | High | 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. | 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. | Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required. | Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required, and further information provided as evidence. | Kirsty Thomson, Head of Fundraising :Awyr Las | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/01/2023 | | 0 | 24/04/2023 | 22/08/2023 | Yes | |
| 202 | PFIG | Internal Audit | Delivery of Health Board Savings | 2023 | Limited | High | Effective governance and oversight arrangements to deliver savings | The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes. | The targeted delivery of operational savings has been progressed within the Health Board and delivered for the 2023/24 financial year. | October update - The Savings Plan process, including the associated requirement guidance and templates has been fully refreshed in 2023/24 and has been issued as part of the 2024/25 Annual Plan process. All savings schemes need to have approval sign off from: <ul style="list-style-type: none"> The Programme Board, which includes the Programme Sponsor and Programme Finance Lead Operational Lead (this may be a Clinical Lead) and budget holder(s), if different. The IHC/ Service Directors in the scope of the scheme CFO(s) in the scope of the scheme All Savings are reported to Welsh Government through the Monthly Financial Monitoring Return signed off by the Executive Director of Finance and CEO. Executive Committee, PFIGC and Board receive regular reports on the Savings Plans and delivery. Performance is also discussed at the Integrated Delivery Group. | Further evidence relating to BCU savings reporting provided as assurance for closure. | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/04/2023 | | 0 | | 25/10/2023 | Yes | |
| 204 | PFIG | Internal Audit | Management of Utilities | 2022 | Substantial | Medium | Health Board EFPMS performance | Management to identify what actions are required to reduce consumption in the sites identified in order to meet the all Wales KPI for net energy consumption. Where actions are already planned i.e. as part of the Decarbonisation Energy plan, this should be clearly stated. | Operational Estates are working in partnership with Local Partnerships, Welsh Government Energy Services and Re-Fit Cymru in developing a framework to deliver the Health Board's Decarbonisation Action Plan relevant to Buildings. The framework will look at opportunity to invest in self generating energy sources i.e. Solar PV and energy reduction project by upgrading existing engineering infrastructure i.e. LED Lighting, HVAC etc. The project will be delivered over 2 phases with an estimated completion date for the framework by 2030. | Re:fit programme approved to proceed to invitation to Tender in PFIG which will appoint an Energy Performance Contractor to support the Health Board | The paper had been ratified and agreed at PFIG. Additional evidence provided, and action can be closed. | Arwel Hughes, Head of Operational Estates - Interim | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/06/2023 | | 0 | 30/06/2023 | 22/08/2023 | Yes | |

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| 205 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | High | PADR Compliance and WARRN training | Further progression is needed in order to achieve the overall divisional completion target of 85%. Focus is necessary to increase the uptake of training within areas of the division | Divisional PADR compliance rates to be an Agenda Item in all local Operational Delivery meetings, with focus on staff who have never had a PADR (as at 31st January 35 Divisional staff recorded). Never has a PADR Starter (as at 31st January 43 Divisional staff recorded). Out of date 24-months (as at 31st January 35 Divisional staff recorded). PADR completed but not recorded (as at 31st January 4% (n76) noted). To ensure the Division meets the target compliance of 85% by 31/5/2023. Business Support Managers to include a detailed analysis of area PADR compliance data in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss PADR compliance rates during local area Operational Delivery meeting, identify any barriers and support needed to ensure compliance of 85% is met by 31/5/2023 across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include PADR compliance rates, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting (formally DSLT Finance and Performance meeting, Tier 2) to monitor and review progress. The Divisional Key Performance Indicators aligned to PADR to be scrutinised and any additional intervention discussed and agreed for areas under achieving. Reaffirm importance of and recording of PADRs within the MH&LD Staff Briefing. Include monthly PADR compliance rates in the Divisional Improvement Plan KPI data to show trajectory of improvement. WARRN TRAINING. Identify and book alternative accommodation to enable WARRN training sessions to accommodate 25 staff, instead of current 15 staff, to enable an increase in numbers of staff trained each month in order to increase training compliance from 62.5% to 85% by 30/9/2023. Provide monthly WARRN training compliance data, including analysis of individual area/departments compliance, to HSE NOC Delivery Group meeting to enable monitoring, review and early identification of any barrier to delivery of meeting compliance target rate of 85% by 30/9/2023. Continue with delivery of twice monthly WARRN training sessions to ensure an additional 200 divisional staff complete WARRN training to meet 85% compliance. Set up a process to ensure new starters in the MH&LD Division are included in the monthly WARRN training sessions. | MH&LD Divisional PADR compliance report recording 85% PADR compliance across the Division. Report presented and shared at Operational Leadership Meeting and will be shared at the forthcoming Service People and Culture meeting due to be held on 3/7/23. PADR Compliance report attached. Update on WARRN training - MH&LD Divisional WARRN training compliance at 81% up to 18/6/23. WARRN training compliance report attached. Twice monthly training course continue to be held. MH&LD Divisional PADR compliance rate at 85% for two consecutive months (April 23 and May 23). Report attached as evidence. Action completed. | MH&LD Divisional PADR compliance remains above 85%, with October compliance recorded at 86.79%. MH&LD Divisional PADR compliance is presented at the MH&LD Service, People and Culture meeting, latest PADR report and Agenda embedded below. In addition PADR compliance is included in all local area Performance reports (embedded below) with Exception reports presented in MH&LD Divisional Finance and Performance meetings. | Adrienne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MHL | Final Client approved | 30/04/2023 | | 0 | 26/06/2023 | 31/08/2023 | Yes | |
| 208 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | High | Ockenden Recommendations | Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to address the vacancies within the division and ensure stability of the management. | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and any additional intervention discussed and agreed for areas with high number of vacancies. Divisional Accountability meetings with each area to be stood up to support the additional scrutiny and interventions required to vacancy position, recruitment processes and accuracy of data. Provide ongoing progress of the Just R Marketing campaign within the MH&LD Staff Briefing. Discussion of monthly Divisional Vacancy and Recruitment report at MH&LD Service People and Culture Delivery Group meeting. On-going progress with Just R Marketing campaign, talent pool process and further development of innovative approaches to address the number of vacancies across the Division. Creation of Quarterly report which will be presented at Operational Leadership Meeting (OLM) feeding into MH&LD Senior Leadership Team meeting to show impact and outcomes of the Just R Marketing campaign, to discuss and agree any further plans to address current vacancies across the Division. Ongoing progress and delivery of actions included in the Wellness, Work and Us Year 3 plan aligned to staff recruitment and retention, with creation of 36 month report to show impact, outcomes and recommendations aligned to addressing staff recruitment and retention. Continued monitor and review of Workforce work stream programme plan, recording and reporting impacts and outcomes of delivery. Development of a MH&LD Recruitment and Retention Strategy to ensure short, medium and long term focus on workforce recruitment and retention across all staff group within the Division. Review of all interim posts across the Division. Discuss and agree a plan to progress with substantive appointment to posts aligned to the MH&LD Operating Model. | The draft MH&LD Recruitment and Retention Strategy/Plan has been signed off and actions are progressing. Quarterly updates will be provided to MH&LD divisional SLT. Whilst some senior interim positions remain, these are longer term thus provide a greater level of stability than short term appointments, and a plan is in place for permanent recruitment. Therefore the proposal is to close this action. | MH&LD Divisional Recruitment and Retention plan developed and approved through respective Governance routes (copy provided for evidence). This ensures the Division has a clear recruitment plan in place to address the vacancies within the division. Just R 12 month recruitment plan ended September 2023 with transition plan agreed for utilising BCHUB External website and Social Media to continue showcasing the Division with the inclusion of microsite, live vacancies and talent pool vacancies. This provides a mechanism to support recruitment activities, as is part of the MH&LD Divisional Recruitment and Retention plan. Impact report on the Just R Campaign to evidence return on investment presented at the MH&LD Service, People and Culture Group meeting, and additional evidence provided. | Adrienne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MHL | Final Client approved | 30/06/2023 | | 0 | | 31/08/2023 | Yes | |
| 209 | PFIG | Wales Audit Office | Audit Wales CHC follow-up | 2022 | Reasonable | Medium | Continuing Health Care (CHC) Training Programme | The CHC Team, working with colleagues in Health Communities/Divisions/Pan-North Wales services agree a method to capture training needs analysis information upon which directed training can be planned and delivered. | Complete Learning Needs Analysis to identify training requirements and support the basis for planning further training activities, education approaches and methods; Learning Needs Analysis will expand on the Education Strategy and be coordinated through the CHC Strategic Joint Education Group (with LA partners). Mapping of training will capture relating framework, such as 117 aftercare. Innovative approaches to be considered and agreed (for CHC and Broadscale training) include multi-choice quizzes at the end of training modules, training videos, online feedback, Webinars, BetsiNet Newsfeed; continue to work with ESR to further develop accessible electronic CHC training modules; Improved data collection through group discussions, training needs assessment questionnaires/rolling review of feedback forms and surveys, skills and knowledge analysis, observations from lessons learned; Develop CHC Competency Framework by end of March 2023 with ambition to implement summer of 2023. CHC covers a diverse and specialised range of skills and the Framework will identify skills and knowledge required; Explore training appraisals within PADRs and make recommendations to the operational teams for implementation. Implement training module to communicate Lessons Learned from Appeals and Retrospective Claims to the wider Health and Social Care system; coordinate through the CHC Strategic Joint Education Group; Share training attendance registers with operational line managers across the wider Health Board to address any issues of non-attendance and develop an action plan; Embed CHC Foundation module into core 'business as usual' training as part of the 2023 rolling training programme; the Foundation module will be delivered on a monthly basis from January 2023 and publicised via the BetsiNet CHC page and via the CHC Strategic Joint Education Group. | Training has been prioritised during 2023. This includes shifting the perspective on CHC training to consider it as a core business activity rather than a 'nice-to-have'. TNA approach taken and resources developed in line with this; strategic goals defined; required skills and knowledge outlined; current skills evaluated; performance gaps identified; generic and bespoke sessions implemented. 2024 rolling programme being finalised and modules being updated in light of new D2RA pathways and feedback; All the above have supported establishing training needs. Incremental approach to competency framework adopted; first phase pre and post training self-assessment competency questionnaire implemented (it remains that learners need considerable coaxing to complete and this is an ongoing challenge with creative approaches being adopted); lessons learned module being finalised for roll out 2024; training attendance data is shared with IHC's and LA's; strategic joint education group with 6 NW LA partners continues and attendance at joint QAF Education, Training and Support Working Group secured (from October 23); CHC training reintroduced at Glyndwr and Bangor Universities post-Covid. October update - Revised Imp Date: 01/09/2023. | Confirmation that this item has been signed off following implementation of above listed actions. This item has also been signed off as a previous corporate risk. This recommendation can therefore be closed. | Jane Trowman, Head of Strategy and Health Planning | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/03/2023 | 01/09/2023 | 1 | | 28/11/2023 | Yes | |
| 211 | PFIG | Wales Audit Office | Audit Wales CHC follow-up | 2022 | Reasonable | High | Governance, accountability and performance | The Health Board review the governance and accountability arrangements for CHC which brings together people, quality, performance and financial information. | Continuation of Contracts and Finance reports to PFIG. Continuation of Quality Assurance Framework update to Regional Commissioning Board and Regional Partnership Board. CHC reporting structures (Quality, Finance, and Performance) will be reviewed and there will be a recommendation made to the Executive team regarding a proposed governance and reporting structure for CHC. This will include a proposal that there is Executive Board agreement regarding the Exec lead for CHC, in line with the new Operating model. It will also help to formalise reporting, ensuring a quarterly report goes to a sub-group of the Board. Terms of Reference for CHC/Care Home Quality and Commissioning Group (SMT) will be reviewed. This will strengthen SMT membership in line with recent changes and establishment of IHCs. Further work will be carried out to align the IHC and corporate risk registers. The updated corporate risk register will then be issued for Executive sign-off. The CHC Operations Group TOR will be reviewed to ensure there is a strategic focus, as operational items are included in the Case Management Group remit. | Contracts and Finance reports to PFIG and QAF update to Regional Commissioning Board and Regional Partnership Board continues (complete). Corporate CHC will remain with Executive Director Transformation and Strategic Planning, and Commissioning with Finance and Contracts (complete). Revised ToR were approved at January 10th SMT meeting and circulated post meeting. Following this an updated meeting agenda, membership and reporting format has been introduced for Sept 5th SMT. (complete) IHC and corporate risk registers aligned. This will be part of monthly review in line with corporate risk register requirements. (complete) ToR updated and included in June CHC Ops Chair's report for SMT 04.07.23. The Agenda/reporting format will be reviewed in line with updated SMT Agenda introduced Sept 2023. (complete) October update - SMT Agenda re-focused Sept 2023 in line with Special Measures requirements and is focused on 3 elements; Safety and Quality, Performance & Finance and Contracting. A consolidated update is issued 1 week after SMT that can be used for information/update/escalation within corporate, IHCs and divisions. Revised Imp Date set to 30/09/2023 | Action complete, and can be closed. Additional evidence provided as latest SMT update. | Jane Trowman, Head of Strategy and Health Planning | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/03/2023 | 30/09/2023 | 1 | | 28/11/2023 | Yes | |

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| 212 | PFIG | Internal Audit | Digital strategy | 2023 | Reasonable | High | | Funding the implementation of the Digital Strategy | The Chief Digital and Information Officer, working with Finance colleagues: • identifies the costs associated in implementing the digital strategy. • ensures the budget report accurately reflects the funded establishment. • where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee. | Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPPH that includes the details about unfunded projects and the risks associated with stopping those. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24. | A full review of the DDaT Budget has been undertaken and many previous cost pressures for 2022/23 have been funded. The DDaT IMTP submission has not been funded due to constraints across the Health Board. Some of the national projects and programmes did come with funding and some have brought additional pressures to the Health Board. A list of unfunded projects and the risks associated with non-delivery has been developed and is in the process of being reported to the PPPH Committee when it starts again. The costs of delivering the entirety of current Digital Strategy have not been fully quantified or funded and the risks associated with that are in the BAF with an accepted level of tolerance. 2.5. 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. 2.6 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. As a result DDaT are working on a re-baselining and revision of the Digital Strategy which following consultation will be ready in draft in early 2024. | The Chief Digital Information Officer has accepted this position as the Health Board are tolerating the risk which has been escalated to the Board and accepted. There is nothing further the Digital, Data and Technology Division can do to address this recommendation due to the Health Board's decision making in the current financial climate. Digital, Data and Technology Division will continue to put forward for all available funding in future years. Additional evidence provided for closure. | Andrea Williams, Head of Informatics Programmes Assurance and Improvement | Dylan Roberts, Chief Digital and Information Officer | Final Client approved | 30/06/2023 | | 0 | 30/06/2023 | 15/08/2023 | Yes | |
| 219 | QSE | Internal Audit | Public Health - Smoke free sites | 2023 | Reasonable | High | | Policy not up to date | Smoke free policy WP31 is progressed and agreed through the appropriate process as a matter of urgency to become compliant with legislation | Receive confirmation from the Board regarding position of smoking shelters across BCUHB in relation to legislation. Feedback to the WOD policy group on acknowledgment of their concerns and our position in line with legislation/ board decision and sign off. Once approved, submit policy to relevant approval groups for ratification. Once ratified, develop communications plan to promote revised policy across the organisation and add to BetsiNet policy pages. On-going review of management plan to ensure policy has been implemented. Review policy for any amendments regarding enforcement/compliance that develop throughout the year. Ensure BCUHB Smoke free Policy links with further policy development across each of the 3 acute hospital sites to support compliance with smoke-free legislation (including due diligence and reasonable steps). To include working with IHC's and Hospital Leads on developing, implementing and monitoring smoke-free hospital plans that support the wider BCUHB smoke free policy. | October update - issue resolved around smoking shelters in relation to the policy and we will not be supporting smoking shelters across BCUHB premises. WP31 policy has been approved, signed off and has been disseminated and communicated across the health board. It is available via the workforce policy pages on BetsiNet. A review of the policy will be made once all environmental officers have been employed and in place across the health board. PHW colleagues are working with the IHCs to implement a management plan in support of the policy. October 2023 - item to be marked as green/completed, as the Smoke-free Policy has now been updated and approved through the relevant process, also with dissemination and comms taking place. The remaining work regards ensuring compliance of the Policy and it's review will be ongoing and involve a number of actions in working with staff, line managers, IHC's, recruitment of environment officers. | A considerable amount of work is ongoing in relation to review and engagement, and this forms part of the plan to work with the IHCs on the longer term management of the policy. Additional evidence provided to support closure. | Gavin Jones, Health Intervention Co-ordinator | Teresa Owen, Executive Director of Public Health | Final Client approved | 31/10/2023 | | 0 | | 27/10/2023 | Yes | |
| 221 | Audit Committee | Wales Audit Office | Audit Wales Follow up - counter fraud | 2022 | Reasonable | Low | | Recommendation 2 Resources and Skills | The Executive Director of Finance reviews succession planning and service continuity arrangements in line with the Audit Wales report, factoring in other NHS Wales comparators. | The Executive Director of Finance and the Finance Director: Operational Finance have reviewed the structure of the department with the Head of NHS Counter Fraud Wales including benchmarking both the amount of resource and the structure with other Health Boards across Wales. This process will continue to be monitored with the Head of NHS Counter Fraud Wales and all options will be considered for the most appropriate structure and resourcing of the department. | Agreement reached to submit a re-banding for a Deputy Head of Counter Fraud post (B7) - awaiting outcome of evaluation awaited. This would bring the structure of the team in-line with recent changes to the LCFS Teams across Wales. | Re-banding of Deputy Head of Counter Fraud post accepted and submitted to payroll. Paper on future services presented through the Executive Directors of Finance All Wales meeting, and copy provided as additional evidence. | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 07/12/2022 | | 0 | 07/12/2022 | 22/08/2023 | Yes | |
| 222 | Audit Committee | Wales Audit Office | Audit Wales Follow up - counter fraud | 2022 | Reasonable | Medium | | Recommendation 2 - Fraud Risks | Current ownership of fraud risks is reviewed and transferred for operational management and control where appropriate. The Counter Fraud Team works in partnership with the Risk Management Department to embed operational services ownership and identification of fraud risk in their day-to-day processes and any risks specific to the Counter Fraud team are reviewed on a regular basis. | The Director of Finance: Operational Finance has directed the Head of the Health Board's Local Counter Fraud Service to work with the Associate Director of Governance to agree the Agreed Management Action. Whilst the actions have individual action owners, the Associate Director of Governance will take responsibility to make sure they have been completed. Discussions have taken place with the Associate Director of Governance during November 2022 and have initially focused on the Management Actions which are required to be undertaken, to mitigate the Counter Fraud risks, to an acceptable level to achieve the Target Risk score - to allow the risks to be closed on the Risk Management system. The Associate Director of Governance will be tabling this at the BCUHB Risk Management Agenda Item in the BCUHB Health Board Leadership Team in January 2023 and the Risk Management Group in February to check and confirm that all actions have been taken. Associate Director of Governance to formally report to Audit Committee on a quarterly basis on the number of Fraud Risks which are being recorded by each of the Health Boards operational service departments. | The Board Secretary will now work with Finance Team and Fraud Team. This was agreed at the HBLT on the 3rd May 2023. Industrial Action took place and therefore Risk Management Group wasn't able to review actions of Counter Fraud risks were reviewed as part of the Risk Management Group in March 2023 and will be reviewed again in June 2023. In June 2023 they will have a bespoke agenda item | This action can be closed. The Risk Management Group met on 5th June 2024 and this agenda item was on the agenda. Regular meetings take place with both the Board Secretary and the Head of Risk Management. Counter Fraud is to be added to the cycle of business for RMG annually and a report was presented at RMG where it was noted the Fraud Risk Register needed to be updated, working with the risk team will now be business as usual. Additional evidence provided to support closure. | Phil Meakin, Associate Director of Governance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/12/2022 | 06/12/2023 | 2 | | | Yes | |
| 225 | PFIG | Wales Audit Office | Audit Wales Structured Assessment 2020 | 2020 | N/A | High | R3 | Reporting progress against delivery of plans: Ensure that outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes. | The plan for quarters 3 and 4 is stronger on outcomes at a programme level than previous quarterly plans. Our chosen outcomes tie back to Living Healthier Staying Well and national outcome frameworks. Performance trajectories are also being developed for this planning round. In respect of reporting against performance, through direct engagement with operational leads, we are strengthening the narratives required for actions that are off track. Furthermore, we are looking at triangulation with the performance measures outlined in the NHS Wales Delivery Framework and how plan outcomes are impacting upon these. | Update provided by Executive Director of Finance. An update has been provided to the board that includes NHS Wales Delivery Framework and narrative to articulate performance. The IQPF requires some further refinements in line with the development of the Integrated Performance Framework. However, assessment is that the rec can be closed. | IPR has now been agreed by the board and is being used in Health Board meetings. Additional evidence provided for closure | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/11/2020 | 31/12/2022 | 6 | | 22/08/2023 | Yes | | |
| 228 | PFIG | Internal Audit | Continuing Healthcare Arrangements | 2020 | N/A | High | R8 | While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management. | A transition plan has been agreed to consolidate the corporate CHC leadership team. This team will now oversee CHC and the care home sector reporting into a substantive Assistant Director of Primary and Community services from 1 January 2021. | Agreed as complete on local CHC Audit Action Plan 07/03/23. | Confirmation was given by the Executive Director Transformation and Strategic Planning that he will remain the executive lead for Corporate CHC subject to any later/further review of Executive portfolios. An Acting Assistant Director for Care Homes and CHC Commissioning has been appointed, which has been extended to December 2024 to ensure continuity and leadership for the corporate team. | Kathryn Titchen, Commissioning Manager CHC | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/01/2021 | 07/03/2023 | 9 | | | Yes | | |
| 243 | QSE | Internal Audit | Managing Medicines in Primary and Secondary Care | 2016 | N/A | High | R1 | The Welsh Government, NHS Wales Informatics Service and all health bodies should agree a detailed, time bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery plan. | The NHS Wales Informatics Service (NWIS) has established the Welsh Hospital Electronic Prescribing and Medicines Administration (WHEPMA) project to develop and implement the national plan for electronic prescribing in secondary care and the inaugural meeting of the project board was held on 23 November 2016. The project team is currently working with stake holders to define the exact scope of the project and the system requirements. Once this is complete the business case for procurement of a replacement hospital pharmacy system and an electronic prescribing and medicines administration solution will be completed by NWIS and considered by Welsh Government. Subject to the completion of the business case, it is expected that the procurement of these systems will be completed during 2018-19 with implementation beginning in the early part of 2019. Identify a BCU representative for the national project board and a medical, nursing and pharmacy link for the project by April 2017. National project to present the strategic outline business case to QSG/EMG by June 2017 prior to submission to WG. Establish a BCUHB implementation group by September 2017. | EMPA Board established. SRO Executive Director of Nursing and Midwifery - programme board chaired by deputy director of nursing and midwifery. Pre-implementation plan ongoing within programme timescales. Further programme update planned for January 2024 | Evidence of Terms of Reference and notes of August health board programme board meeting (October note not yet available), and National Secondary Care programme board highlight report provided as additional evidence. 1. Electronic Prescribing and Medicines Administration (ePMA) Programme Board established (ToR and notes of recent meeting) 2. Senior Responsible Officer (SRO) and Programme Board chaired by Deputy Executive Director of Nursing and Midwifery. 3. Pre-implementation plan and programme milestones agreed by the Digital Transformation Medicines Portfolio and Welsh Government ePMA national board. 4. Health Board Business Case mid-drafting (November 2023) Additional Evidence Supports closure. | Lois Lloyd, Interim Chief Pharmacist | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2017 | 31/01/2024 | 16 | | | Yes | | |
| 246 | PFIG | Internal Audit | Financial Control - Receipting of goods and year-end accruals | 2023 | Reasonable | High | | Procurement guidance and training | Ensure all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. Review the evidence provided for Purchase Order 9705645 for £293,787 and ensure it is accounted for in the correct financial year. | In relation to training, we have to date focused on the provision of essential guidance and training on year-end processes for BCU colleagues in order to mitigate the risk of expenditure being accounted for across BCU in the wrong year at the 2022/23 year-end. Acknowledgment of this is welcome. The assessment of longer-term training needs and the delivery of an ongoing programme of training across BCU are addressed in the Financial Control Environment Action Plan. In relation to the specific Purchase Order 9705645 we confirmed that this was not accrued for in the 2022/23 year-end. It will be accounted for as appropriate in 2023/24. | Item 7 in the Financial Control Environment Action Plan, which is monitored fortnightly by WG in conjunction with Special Measures, includes a learning lessons process. The inclusion of the audit for the 2022-23 financial year provides assurance these lessons have been learned with balances endorsed as true and fair by Audit Wales. | Additional evidence of Oracle Refresher Workshop provided | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2023 | 01/11/2023 | 1 | | 22/08/2023 | Yes | |

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| 248 | People Committee | Internal Audit | Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 2023 | Limited | High | Standing Orders Compliance | The engagement of all Interim/agency appointments must comply with the Standing Orders, Standing Financial Instructions and associated Delegated Matters/Scheme of Delegation and Standard Operating Procedure. Issues of non-compliance must be included in all relevant Performance and Accountability meetings with clear actions Minuted and officers held accountable for continual non-compliance. | 2.1a A recent revision to the standard operating procedure F18, senior nonclinical agency interim engagements (v11) now incorporates a maximum contract length of 4 month for every request. Similarly, the Executive Director of Finance is now a co-approver of all new interim requests. A further addition will be made that will require a full contract value calculation to be undertaken by the requesting manager upon submitting the IAR, which will be validated against their SFI limits. This will require the requestor to liaise with their finance CFO to accurately quantify the total cost of the interim engagement. 2.1b Non-compliance with WG required processes, Standing Orders and SFIs will be reported to RTS (quarterly) and PFIG (monthly). Repeated non-compliance with process, by a single department, will be escalated to audit committee; the parameters of which will be defined in the response to point 3 below. Upon requesting an interim worker for a VSM post, the IAR form will be updated so the requestor will be asked to confirm they have been in contact with WG head of profession. The recruitment team will ensure all VSM posts are communicated to the relevant WG leads before any appointment is confirmed. | July rem com received the first report identifying compliance against SOP etc, September meeting will identify further escalation for reported non-compliance into the AC. Areas of non-compliance are reported to the CEO and the Exec team | The format and content of the senior interim report was approved in September 2023, with an excerpt from the August 23 REMCOM meeting provided as further evidence. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 31/06/2023 | | 0 | | 30/08/2023 | Yes | |
| 249 | People Committee | Internal Audit | Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 2023 | Limited | High | Remuneration and Terms of Service Committee – Reports for assurance | Management must ensure Committee Members are appropriately involved in determining the information they require for assurance and subsequent reporting/providing advice to the Full Board. As a minimum, any report to be submitted to the RATS Committee in relation to the appointment of an interim must incorporate assurance on compliance on key matters of control in Standing Orders, Standing Financial Instructions and Welsh Government instructions. | R&TS committee Terms of Reference is being updated and will be ratified in May 2023. The R&TS committee will define the required parameters of the reporting structure and make it's recommendations to board. A new reporting template for R&TS and the Executive Management Team will be implemented, to incorporate all JESP/VSM appointments, both interim and substantive, and whether the appointments are compliant with standing orders, SFIs and WG instructions. In addition, the report will include details of permanent recruitment timeframes when a post has been filled by an interim. | | The REMCOM terms of reference were approved, and have been provided as evidence. The senior interim report that was agreed in September 2023 will be provided to every meeting (bi-monthly) until further notice. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/09/2023 | | 0 | | | Yes | |
| 250 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | Medium | Risk Management department duties | The Strategy is updated to include the duties of the Risk Management Department. | The Risk Management Strategy to be revised to include the duties of the Risk Management Department. | The revised RM01 draft makes provision for Corporate Risk Management team duties and will be submitted to Sept Board 23 for review/approval. October update - The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23. | The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23. Additional Evidence provided to support closure. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 28/09/2023 | 1 | | 25/10/2023 | Yes | |
| 251 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Oversight, scrutiny and challenge of CRR and BAF | The Health Board must ensure meetings within the governance structure take place as required, to allow adequate review and scrutiny of the risks facing the Health Board. Clarification is required on how often the Health Board and Audit Committee receive the CRR and BAF for review and scrutiny. | Review of the CRR review frequency (RM Strategy), within the Board and committee structure. The Health Board and Audit Committee to have a Cycle of Business to include the CRR and BAF for review and scrutiny (additional IA comments to the Management Response - We note the management action to consider where the CRR is reviewed, however management need to ensure these meetings take place to ensure sufficient scrutiny of the CRR). | The OBS Independent review is now complete, which included a review of Committee ToRs. This will influence the outcome of this rec and therefore a revised date has been set end of September pending CEO/Board review. The board is also pending appointment of permanent Members to enable committee meeting to take place. The TOR on receiving the CRR and BAF will subsequently be set out in all TOR. October update - The revised RM01 details COB for BAF and CRR and was approved at Sept Board 23. All COB for committees /Board also reflect this change. | The revised RM01 details cycle of business for Board Assurance Framework and Corporate Risk Register and was approved at September Board 2023. All cycle of business for committees/Board also reflect this change. Additional Evidence provided to support closure. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 31/09/2023 | 1 | | 25/10/2023 | Yes | |
| 253 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Escalation and de-escalation of risks | Clarification is required on the Committee approval process for the escalation and de-escalation of risks. | Review of the RM02 v3.9 to indicate the QSE approves the escalation/de-escalation of risks. | The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02 where this process will be outlined, including in TOR for RM02. October update - The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the Board Assurance Framework and Corporate Risk Register are a standing agenda item on bi-monthly basis as well as risks to be escalated/de-escalated. | The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the Board Assurance Framework and Corporate Risk Register are a standing agenda item on bi-monthly basis as well as risks to be escalated/de-escalated. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 31/10/2023 | 1 | | 25/10/2023 | Yes | |
| 266 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | Medium | Performance report and measures | The Health Board continue with the improvement plan to review and update the quality performance report to ensure Committees are receiving appropriate, accurate and relevant information. This should assurance mechanisms in place through Board Committees, to ensure the Health Board are sighted on key areas of concern and are provided with assurance that Committees are considering all areas of performance. | The Health Board is reviewing its governance/assurance structures in line with Special Measures – this includes looking at the oversight of performance frameworks and associated reporting, processes and documentation. This will involve the gradual 'integration' of reporting on operational delivery, quality, safety and patient experience, workforce and finance by the end of March 2024. Alongside this includes a Review of the content, editorial ownership and quality of the information and data contained within all performance reporting it. This includes work with informatics to ensure all Operating Framework Metrics, trajectories and other KPIs included in the Board Report have a documented processes and signoff for submission nationally, locally etc. Closer editorial management of the Performance Report now sits with the Director of Performance role. Effective Feb 2023 a summary/highlight report has been introduced to direct reviewers to key points of variation and from June 23 includes NHS Wales published Organisation Performance Reports and where relevant/available the comparative performance across all Wales' Board. Work continues alongside the revision of the Performance and Accountability Framework. | October update - The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25.10.2023. This iteration will be presented at Performance, Finance and Information Governance Committee on 02.11.2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before it's inaugural presentation at Health Board on 30.11.2023. | The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25/10/2023. This iteration will be presented at Performance, Finance and Information Governance Committee on 02/11/2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before its inaugural presentation at Health Board on 30/11/2023. Action complete, with the Health Board receiving at the meeting of the 1st December 2023 the Integrated Performance Report. However, continuous development and refinement of the report will continue. Additional evidence for closure provided. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/03/2024 | | 0 | | | Yes | |
| 269 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | High | Accountability meetings (b) | Review current action tracker to determine whether actions are still relevant. | Action tracker to be reviewed for relevance by end of July 2023. | Recommended to close. Action Tracker reviewed/refreshed. Outstanding actions addressed and closed, refreshed arrangements to document the agreement of actions and outcome of each quarterly review will be done via accountability agreements (under the new Framework). | Accountability meetings now underway. Action to be closed. Monthly Integrated Performance Executive Delivery Group set up chaired by CEO, monthly meetings held every third Wednesday. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2023 | 29/02/2024 | 1 | | Yes | | |
| 271 | People Committee | Internal Audit | Recruitment Improvement Review | 2023 | Substantial | Medium | Published documents | Management to ensure all published documents and guidance notes are relevant, up to date, and reflect current practice/requirements. | All BetsiNet pages that contain information and guidance on the recruitment process will be reviewed and updated, and any documents which are no longer relevant will be archived. | WOD in the process of reviewing library. This will be influenced by the new operating model / structure as the WOD team realigns to the IHCs | As identified in the audit, the recruiting managers guides on BetsiNet have been updated as per the new employment checks process implemented in September 2022 - additional evidence provided to support. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/06/2023 | 30/03/2024 | 1 | | Yes | | |
| 272 | People Committee | Internal Audit | Recruitment Improvement Review | 2023 | Substantial | Medium | Board and Committee reporting | Management to review governance and reporting arrangements to ensure implementation and performance is subject to Health Board review and scrutiny. | A set of recruitment KPIs that can easily identify the Health Board's performance against target time-to-hire timeframes relating to Manager, NWSSP and People Services lines of responsibility, which can also be benchmarked against other Health Boards in Wales, will be included in the workforce performance report that is provided to PFIG committee. This will be supported with contextual information as to actions and issues relating to sustaining acceptable recruitment performance. Moreover, it is expected that the existing workforce BI dashboards, which contain relevant recruitment KPIs, will be utilised in local IHC reporting and oversight. | Recs implemented - KPIs now included in WOD to PFIG. Local IHC dashboard have been developed to provide and rela time info. | The KPIs have been approved by PFIG and have been in place since July 2023, and additional evidence has been provided to support this. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/06/2023 | | 0 | | 30/08/2023 | Yes | |
| 274 | PFIG | Internal Audit | Cyber Security | 2023 | Substantial | Medium | Use of KPIs | KPIs should be developed that show the current security posture of the organisation | As noted in the report, the Cyber Security and Compliance Team have begun a piece of work to develop proposals for KPI's taking into consideration work being carried out nationally. The proposals will be developed ASAP, presented to the CDIO for implementation consideration by the end of Q3, 2023/24. | KPIs drafted, awaiting approval at the local DDaT ICT Governance and Security Group before onward submission to the CDIO. Whilst this is in train, work is also ongoing across Wales to develop standardised KPI and reporting nationally. | The Chief Digital Information Officer has approved the set of Cyber Security Key Performance Indicators, which take into account the requirements of the Network and Information Systems Regulations 2018 will now be implemented and reporting through the standardised governance arrangements via the ICT Security and Governance Group, which reports into the Information Governance Group and then upwards to the Performance, Finance and Information Governance Committee. (This reporting may revert to the Partnerships, People and Population Health Committee when meetings re-commence). Additional evidence to support closure provided | Sion Jones, Assistant Director/Chief Technology Officer | Dylan Roberts, Chief Digital and Information Officer | Final Client approved | 01/09/2023 | 30/11/2023 | 1 | | 29/11/2023 | Yes | |

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| 275 | PFIG | Internal Audit | Accounts Receivable | 2023 | Reasonable | High | Cash Deficit | The Health Board should ensure that any discrepancies between money banked and payments receipts be fully investigated and formally reported to establish reasons and prevent further occurrences. | The discrepancies identified between receipts and bankings have all now been confirmed as being timing differences, which were subsequently banked in all cases. Timing differences arise when cash is taken late in the day and therefore can only practically be banked the following day. Prompt action has been taken to meet with the Catering Manager in Denbigh and Ruthin where the audit findings were discussed and immediate changes to their banking processes have been enacted which will ensure any discrepancies arising from timing differences are explicitly followed through and secure banking confirmed as a matter of routine. Initial meetings have also been held with the Manager and Assistant Manager of YGC Catering, and we are now setting up more robust processes relating to the 'Midnight Till' and where cash is held over before being transferred to General Office. Turnover of cash is reducing due to the fact that card machines are now in the majority of our Community Hospitals. The General Office Manager continues to remind staff of the procedures to follow and actively provides re-fresh training to staff. A planned half-day targeted session with all Community Hospital General Offices is taking place in October, and this will be a further opportunity to reiterate the requirements set out in our procedures and to respond to any practical queries that they may have and to look at best practice. | Reviewed by Exec Director finance - close. | Further evidence to support closure provided. | Ronnie Bright, General Office Manager | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 17/08/2023 | | 0 | 17/08/2023 | 22/08/2023 | Yes | |
| 277 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | Medium | Clinical Audit Plan | The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee. | The Clinical Audit Plan for 2023/2024 was prepared and submitted initially to the Strategic Clinical Effectiveness Meeting on 14th February for discussion and agreement. Following this the Clinical Audit Plan was prepared and submitted to Quality, Safety and Experience Committee (QSE) on 7th March, the meeting was then stood down. The paper was then submitted to Quality Delivery Group (QDG) on 17th April, due to QSE not having any further dates to present at that time and due to changes in Board membership all of the Committees were not meeting at that time. It was therefore appropriate Nick Lyons signed it off as Executive Medical Director and Acting Chief Executive Officer at that time. | The Clinical Audit Plan went to QSE Committee in August and is incorporated into future cycle of business. | The Clinical Audit Plan for Tier 1 went to QSE Committee in August and is incorporated into future cycle of business from Strategic Clinical Effectiveness Group to be submitted when relevant. The quarterly reports show the current situation at that time of relevant published Tier 1 reports and where they are in the cycle process and any concerns are escalated to QDG and QSE where relevant. Processes are in place to flag up concerns on monthly basis within local Clinical Effectiveness Group with approach of sorting those concerns and avoiding escalation where possible. Due to local Clinical Effectiveness Groups running differently on each site, from November the Clinical Effectiveness Team sharing a monthly update to each IHC and Divisions sharing current position with regard to Tier1, Tier 2 and NICE - if any concerns or risks that need addressing, and these will be monitored and if no change escalated then escalated to Strategic CEG. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/07/2023 | | 0 | | 31/08/2023 | Yes | |
| 278 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Clinical Audit participation | The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits. | On the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August a request was made that each local CEG discuss and identify resource gaps and how they come to that conclusion and bring back to CEG 12th September meeting relevant information for us to capture in Chairs Report to escalate to relevant Health Board meetings. | October update - Following on from Internal Audit Review one of the agenda items on Strategic Clinical Effectiveness Group 12th September was a request for each local CEG to discuss and identify resource gaps and how group come to that conclusion us to capture in Chairs Report to escalate to relevant Health Board meeting. Initially we have had updates on Tier 2 and are working through this, nothing has been raised on Tier 1 currently - we will escalate any concerns to QDG and QSE - this can be CLOSED | There is a process in place that concerns with resources for Tier 1 audits need to be brought to Strategic Clinical Effectiveness Group with what has been reviewed with regard to resources, that all options have been exhausted and the need to raise for support. Tier 1 is mandatory and it has been made clear that means BCUHB needs to be participating in these audits and making every attempt to do so. The Chair's report from SCEG will include details that need to be escalated to Quality Delivery Group if further support is needed to address this. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | | 16/10/2023 | Yes | |
| 279 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | Medium | Validation of Data | Clinical Effectiveness Department liaise with the services to establish how the data is validated for each audit, this will enable the department to gain a better understanding of how the data is collected and validated. | Team are non-clinical and would not be able to validate this. At the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August we will request that when each Tier 1 audit is published that the area will need to validate how the data was collected. This will provide assurance and we can capture within our minutes and quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note. | October update - The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead how the data has been validated and noting this to provide assurance within our quarterly reports - This can now be CLOSED | Team are non-clinical and would not be able to validate this as each Tier 1 audit is published they will request detail from the area to validate how the data was collected. This will provide assurance and we can capture within quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note. The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead to identify what validation takes place prior to data submission. This is being recorded on the departmental database and part of our team process to ensure we have all relevant information for reporting to Strategic CEG, QDG and QSE to provide assurance and if there are queries raised that escalation of this is followed. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | | 16/10/2023 | Yes | |
| 280 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Progress reporting of Tier 1 audits (a) | The Health Board must ensure appropriate meetings within the governance structure take place as required and include clinical audit as an agenda point to allow adequate review and scrutiny of the issues affecting the Tier 1 process. | The quarterly reports that are produced from Clinical Audit Team capture which audits have been published in relevant quarter and includes all BCU identifiable data – plus process and completed actions and outstanding issues. These are followed up by Clinical Audit Facilitator at local CEGs. We have recently set up an Audit /NICE monthly meeting and we would capture any areas of concern that need taking to Strategic CEG to close the loop. A cycle of business (COB) has been developed to ensure relevant papers go to appropriate meetings. | | In Clinical Effectiveness Department, we ensure through our processes that we monitor and review any issues affecting the Tier 1 process. These are raised with local Clinical Effectiveness Groups to be aware and discussed how to manage. If failure to address these issues is not met then they will be escalated to Strategic Clinical Effectiveness Group to discuss and if cannot be addressed would be raised in Chairs Report to Quality Delivery Group for decision making. Clinical Audit Facilitator at local CEGs. Our new process is to share on a monthly basis to all IHCs and Divisions an update of current situation with Tier 1, Tier 2 and NICE Compliance in the process and this is shared with Head of Clinical Effectiveness and Deputy Executive Medical Director. Within our CE team we have set up a monthly Audit /NICE monthly meeting and where we discuss areas of concern that need taking to Strategic CEG to close the loop. A cycle of business has been developed to ensure relevant papers go to appropriate meetings. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/03/2024 | | 0 | | | Yes | |

| | | | | | | | | | | | | | | | | | | | | | |
|-----|-----|----------------|---|------|---------|--------|---|--|--|--|--|--|--|-----------------------|------------|--|---|--|------------|-----|--|
| 281 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | Medium | Progress reporting of Tier 1 audits (b) | To enhance accessibility of audit activity, improve timely reporting and keep track of the identified actions, the AMArT system needs to be developed further outside of the department and continue to be implemented throughout the Health Board. | We do currently update AMArT with all Tier 1 information and add on action plans however we need to review if beneficial to be using outside of department. Will look at piloting within couple of Tier 1 areas for feedback at relevant meetings. | | All Tier 1 audit publications are uploaded onto AMArT (Audit Management and Tracking Software) as they happen and details and details entered into the Service Assessment form which note assurance/risk/level or actions to follow. The Audit webpage has information regarding the progress with the expected Service Assessment form and any approved forms are uploaded on to the system. All details are uploaded on to the webpage and it is being promoted regularly. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/12/2023 | | 0 | | | Yes | |
| 282 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | Medium | Learning from audits (a) | Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process. | Following recent meeting with Internal Auditor the Service assessment form was amended July 2023 to request evidence of discussions and how these are shared as part of the assurance process. Clinical Audit Facilitators will ensure that all details are completed before accepting the form as completed and the update will be included in the relevant quarterly report. | October update - The Clinical Audit Facilitators have developed a service assessment for that is sent to each Clinical Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. The process will not be closed until all the relevant evidence has been sent to Clinical Audit Facilitator to include in our Quarterly Reports. Additional evidence to support closure provided. | The Clinical Audit Facilitators have developed a Service Assessment of Compliance against Key standards (KPIs) form which is sent to the Clinical Audit Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. This information is then captured in the Quarterly reports and Annual report and also shared within local Clinical Effectiveness Groups (CEG). We review our processes regularly to ensure we are capturing as much as we can to share at relevant groups. On monthly basis we share an update with IHCs and Divisions on their current position with Tier 1 audits which shows the current position/progress also noting any concerns that need addressing. If this is not done through the relevant local Clinical Effectiveness Groups, then a paper would be produced to take to Stratgic Clinical Effectiveness Group to discuss further. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 23/07/2023 | | 0 | | 16/10/2023 | Yes | |
| 283 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Learning from audits (b) | Clinical Audit updates/Annual Clinical Audit Report to be presented to the Quality and Safety Committee to allow Health Board members the opportunity to challenge and approve the documents. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in CEG and QDG so has mechanism in place to escalate when necessary. | All papers are on Cycle of Business (COB) and when to be presented at relevant meetings. As the QSE has stood down on a number of occasions, after being submitted at the Strategic Clinical Effectiveness Meeting, papers have been submitted at Quality Delivery Group for submitting in August. They will then go to QSE and Audit Committee now that dates have been re-established and agenda confirmed. | October update - Due to the QSE being stood down, at the time papers such as Clinical Audit Plan, Quarterly papers and Annual report were sent to Strategic Clinical Effectiveness Group and then to Quality Development Group. Now that QSE has been reinstated and meeting bi-monthly all those papers have been sent for information and approval. Also this will now be the process we follow to ensure that assurance and approval is received from all relevant groups. This can now be CLOSED | When reviewing the Cycle of Business for Strategic CEG, we took into account when the quarterly reports would be presented, at Strategic Clinical Effectiveness Group and then to Quality Delivery Group within our Chair's Report. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in Strategic CEG and QDG so has mechanism in place to escalate when necessary. We constantly monitor our processes within the team to improve as necessary. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | | 16/10/2023 | Yes | |
| 293 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. | 2.1a Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated. | | Good practice examples shared pan BCNUH alongside ongoing peer review process. In addition, as of January/February 2024 many staff will be required to update their Mandatory Training (which will be via the updated modules). IHC Leads will provide ongoing assurance of local Mandatory Training levels via the monthly Falls Steering Group. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | 31/08/2023 | | 0 | | Yes | | |
| 297 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1c Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms. | 2.1c Training resources outlined 2.1a will include the re enforcement of when the FBHMA requires review and updating in line with national standard. The B6 Clinical MH Advisors now lead the patient risk assessment bedside learning programme (for falls and patient handling risk assessments) for the H&S team. | | New Welsh Nursing Care Record upgrade flags on transfer to ward to complete Risk Assessments. A reminder to complete is also included in the training. The monitoring of compliance as stated is continually monitored and reviewed via existing ward metrics and now also with the peer reviews. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | 30/10/2023 | | 0 | | Yes | | |
| 302 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. | Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments. | | Monthly report now to be submitted to ward accreditation lead nurse to inform on falls training for agency workers. Additional evidence to support closure provided. | Clair Tipton, Head of Digital Workforce and Resourcing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | | | 0 | | Yes | | |
| 305 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section. | 4.1b Action 2 - The Health Board Patient Safety team will provide a weekly report from Datix of the previous weeks closed incidents to monitor quality of completion to be sent to IHC Directors of Nursing and IHC Governance leads to action locally this will be an ongoing process. | | The Patient Safety Team provide a weekly report to IHCs/divisions that identifies incidents reported as moderate and above harm that have been closed without a management review/investigation or have gaps in lessons learned or have not followed process. These are re opened by the Patient Safety Team and communication sent to the person who closed it and the governance lead. A monthly report is also sent for none and low severity incidents that have been closed without a management review. Additional evidence for closure provided. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | | | 0 | | Yes | | |

Follow Up Internal Audit Report

April 2024

Betsi Cadwaladr University Health Board



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Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
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|-------------------------------|--|
| Review reference: | BCU-2324-22a |
| Report status: | Internal Audit Report |
| Fieldwork commencement: | 26 February 2024 |
| Fieldwork completion: | 29 February 2024 |
| Draft report issued: | 29 February 2024 |
| Management response received: | Not Applicable |
| Final report issued: | 29 February 2024 |
| Auditors: | Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit |
| Executive sign-off: | Phil Meakin, Interim Board Secretary |
| Distribution: | Nesta Collingridge, Head of Risk Management Glesni Driver, Head of Covid 10 Inquiry |
| Committee: | Audit Committee |



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

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

Disclaimer notice - please note:

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

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

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

Executive Summary

Purpose

To review the evidence received by the Office of the Board Secretary to support closure of a number of audit actions from various audit reports.

Overview of findings

There was sufficient evidence available to support the closure of 17 actions.

We consider 6 actions to be partially closed, where some evidence has been provided but this does not demonstrate full completion of the agreed action.

We consider 8 actions to be outstanding, where either no evidence was provided, or the evidence provided was not sufficient to support closure of the actions.

Recommendations / agreed actions plans where the evidence is not sufficient and further evidence is required to close, are from the following reports:

- Integrated Service Board Governance
- Charitable Funds
- Recruitment of Substantive and Interim Executive and Senior Posts (ESP)
- Performance Management – Quality and Performance Reporting and Accountability Arrangements
- Clinical Audit – Tier 1 National Audits
- Falls Management
- MH&LD
- Audit Wales CHC Follow up
- Financial Control – Receipting of goods and year end accruals
- Accounts Receivable

Assurance summary

| | High | Medium | Total |
|------------------|-----------|----------|-----------|
| Closed | 12 | 5 | 17 |
| Partially closed | 5 | 1 | 6 |
| Outstanding | 7 | 1 | 8 |
| Total | 24 | 7 | 24 |

1. Introduction

1.1 The value of internal audit reports lies not only in the opinions they contain but also in the opportunities for improvement, which they identify.

In making recommendations and agreeing action plans it is intended that improvements can be made both in internal controls and operational effectiveness. However, in order to ensure that the benefits of this process are achieved it is necessary to subsequently follow up the implementation of the agreed actions in order to assess:

- whether implementation has occurred or been superseded by further events; and
- whether the actions have produced the intended effect.

Follow up is, therefore, a vital element of any audit and it is our policy, in accordance with the audit plans, to revisit previous assignments.

1.2 The objective of this audit is to review the information and evidence received by the Office of the Board Secretary to support closure of actions. We have reviewed this information only and have not sought further evidence from management.

1.3 As per the Audit Charter, Audit & Assurance are required to follow up:

- All recommendations (High/Medium/Low) from Limited / No / Unsatisfactory assurance rated reports; and
- High recommendations from other reports (Substantial or Reasonable assurance rated reports).

1.4 The Office of the Board Secretary provided us with 49 actions. We have reviewed the evidence for 31 of these, in line with the requirements above:

| Type of action | Number of actions |
|--|--------------------------|
| High / Medium / Low actions from Limited reviews | 24 |
| High actions from Reasonable reviews | 7 |
| Medium/Low actions from Reasonable and Substantial reviews | 15 |
| Audit Wales reviews | 3 |
| TOTAL | 49 |

1.5 Of the thirty one (31) actions reviewed, we consider:

- 17 to be closed, with evidence to verify completion;
- 6 to be partially closed, with limited evidence to verify completion; and
- 8 to remain outstanding, with no or limited evidence to support closure.

1.6 For those actions partially closed or outstanding, we recommend the Office of the Board Secretary re-visit the action with the relevant owner to ensure there is evidence to support all agreed management actions.

Appendix A: Status of actions

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|--|-------------------|------------------------------|---------------|-------------------------|--|
| Integrated Service Boards BCU-2122-07 | 119 | ISB Governance arrangements. | Limited | High | <p>Outstanding</p> <p>We were provided with minutes of the Health Board where the updated Scheme of Reservation and Delegation was approved, however the SORD is not included, and this does not address the issues raised in the report re governance of the Integrated Service Boards, such as:</p> <ul style="list-style-type: none"> - Inconsistent Terms of Reference - No evidence of executive level oversight or scrutiny to ensure objectives and actions of the ISBs align with the Health Board - No regular updates received from ISBs to health board committees - Delegated authority re ISB participation is not stated in HB standing orders or scheme of reservation and delegation. |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|--|---------------|-------------------------|---|
| | | | | | <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Details of where there is oversight of ISBs and how this is reported via the Board - Consistent Terms of Reference for ISBs |
| Clinical Audit BCU-2122-13 | 127 | Policy and process in place for clinical audit. | Limited | Medium | <p>Closed</p> <p>The Clinical Audit Policy and Procedure has been updated and is available via BetsiNet.</p> |
| Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website BCU-2223-04 | 170 | Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43) | Limited | High | <p>Closed</p> <p>This review was subject to a full follow up review, where all actions were evidenced as complete.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|-------------------------------------|-------------------|------------------------------------|---------------|-------------------------|--|
| Charitable Funds BCU-2223-14 | 193 | Information provided to the Board. | Limited | High | <p>Outstanding</p> <p>Narrative is provided, however only evidence is link to charitable funds committee papers.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Copy of induction information provided to board members - Feedback received from trustees re frequency and content of information - How Trustees are provided with assurance that the requirements of the Charity Commission are being met, and how changes to requirements are communicated. |
| | 199 | Charity objectives. | | High | <p>Closed</p> <p>The Charity objectives have been updated on the Charity Commission website to include 'extra staff well-being support'.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|--|---------------|-------------------------|---|
| Delivery of Health Board Savings BCU-2223-15 | 202 | Effective governance and oversight arrangements to deliver savings. | No | High | Closed This has been subject to a full follow up review and a new recommendation has been raised. |
| Recruitment of Substantive and Interim Executive and Senior Posts (ESP) BCU-2223-C32 | 248 | Standing Orders Compliance. | Limited | High | Closed Narrative is provided, however no evidence is provided to support this. However through our current work we have confirmed that this report is provided to the Committee and are content to close the action. |
| | 249 | Remuneration and Terms of Service Committee – Reports for assurance. | | High | Outstanding Narrative is provided, however no evidence is provided to support this. A governance report to the Health Board outlining chairs actions, common seal, Standing orders and proposal for BCUHB Committees and advisory groups was received. No evidence was received relating |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|--|-------------------|---|----------------|-------------------------|---|
| | | | | | <p>to reports to the Remuneration and Terms of Service Committee.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Remuneration and Terms of Service Committee terms of reference re reporting requirements - Regular reporting to the committee on JESP/VSM appointments. |
| <p>Risk Management and Board Assurance Framework BCU-2223-02</p> | <p>250</p> | <p>Risk Management Department duties.</p> | <p>Limited</p> | <p>Medium</p> | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However as part of the current review of Risk Management, RM01 is being reviewed and includes the duties of the Corporate Risk Team.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|---|---------------|-------------------------|---|
| | 251 | Oversight, scrutiny and challenge of CRR and BAF. | | High | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However, through our attendance at the Risk Management Group and other Committees, we can see regular oversight, scrutiny and challenge of the Risk Register.</p> <p>Whilst we have closed the action, we note that there is work ongoing to update the BAF, and are satisfied that this work is progressing sufficiently.</p> |
| | 253 | Escalation and de-escalation of risks. | | High | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However, as we attend the Risk Management Group, the RM02 was presented which includes information on escalation and de-escalation of risks and where this sits for different categories and Tiers of risks.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|----------------------------------|---------------|-------------------------|--|
| Performance Management – Quality and Performance Reporting and Accountability Arrangements BCU-2223-26 | 266 | Performance report and measures. | Limited | Medium | <p>Closed</p> <p>A revised performance report was presented to the Health Board in December 2023. This includes a summary of escalated performance measures.</p> <p>It is recognised that this work is ongoing, however we consider sufficient progress has been made to date to close the action.</p> |
| | 269 | Accountability meetings (b). | | High | <p>Outstanding</p> <p>No revised action tracker received and no evidence of accountability meetings being undertaken.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Revised action tracker to confirm actions are reviewed regularly |
| Clinical Audit – Tier 1 National Audits | 277 | Clinical Audit Plan. | Limited | Medium | <p>Outstanding</p> <p>Narrative states the Clinical Audit Plan for 2023/24 went to the Quality Safety and Experience Committee in August 2023,</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|-------------------------------|---------------|-------------------------|---|
| BCU-2324-04 | | | | | <p>however no papers are attached. The published agenda for the August meeting does not include the Clinical Audit Plan for 2023/24.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Agenda and minutes confirming the Clinical Audit Plan for 2023/24 was presented and approved at the QSE Committee |
| | 278 | Clinical Audit Participation. | | | High |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|--|
| | | | | | <p><i>done and what other avenues have been looked at to deliver the audits. If issues remain then this can be escalated outside of SCEG (Strategic Clinical Effectiveness Group) as required.</i></p> <p>We consider this action closed, however have not confirmed current Tier 1 audit progress, or whether the escalation process has been required to be used.</p> |
| | 279 | Validation of Data. | | Medium | <p>Closed</p> <p>Narrative is provided and a revised Service Assessment of Compliance against Key Standards (KPIs) form was provided. From December 2023, the form includes a section to be completed for all audits that asks ' How was the data validated within BCU for the period covered by this national report publication?'</p> <p>We consider this action closed as the form reflects the information required, however have not received or reviewed any completed forms.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|--|---------------|-------------------------|---|
| | 280 | Progress reporting of Tier 1 audits (a). | | High | <p>Partially closed</p> <p>A draft Clinical Effectiveness Assurance report was received, however this had comments/changes included and it is not confirmed where this has been presented</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Assurance report presented to the relevant group /committee |
| | 281 | Progress reporting of Tier 1 audits (b). | | Medium | <p>Closed</p> <p>Information on the progress of Tier 1 audits is included on the Clinical Effectiveness intranet page (latest update is February 2024).</p> |
| | 282 | Learning from audits (a). | | Medium | <p>Partially closed</p> <p>Whilst an example of a completed form was provided, which states where learning was discussed, there was no evidence to support this i.e. papers / minutes.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---------------------------------|-------------------|---|---------------|-------------------------|--|
| | | | | | To close the action, the following needs to be evidenced: <ul style="list-style-type: none"> - Monthly update to IHCs - Quarterly reports - Example evidence i.e. completed form stating where findings were discussed and evidence to support this (papers / minutes / emails to staff etc.) |
| | 283 | Learning from audits (b). | | High | Closed Outcomes of audit reports are summarised in quarterly reports that are provided to QSE. |
| Falls Management BCU-2324-05 | 293 | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA)(a). | Limited | High | Partially closed The e-learning module has been updated and includes examples of good practice / how to complete documents. Whilst this is positive, there was no evidence provided to support review of compliance figures through the monthly falls steering group (as stated in update). |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|---|---------------|-------------------------|---|
| | | | | | <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Evidence of regular review of compliance with learning via the monthly falls steering group |
| | 297 | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA)(c). | | High | <p>Partially closed</p> <p>Guidance has been issued to reinforce the need to complete the risk assessment, however there was no evidence to support review of compliance figures, as stated in the recommendation /action.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Ward metrics to support monitoring / compliance with completion of FBHMA |
| | 302 | Training. | | High | <p>Partially Closed</p> <p>Training provided to Agency workers has been confirmed, and they now have access to the Health Board e-learning packages.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|---|
| | | | | | <p>Agency staff are encouraged to complete these, and Agency worker induction documentation has been amended.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Agency worker induction documentation - Evidence of regular review of compliance re agency uptake of falls e-learning |
| | 305 | Governance. | | High | <p>Closed</p> <p>Evidence received that demonstrates a review of incidents reported as moderate and above harm that are closed without management review / investigation / lessons learned, which are then sent to IHCs to action.</p> <p><i>Note – whilst closed, we have only considered the central review of this information and not reviewed the outcome of any review by IHCs.</i></p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|---|---------------|-------------------------|--|
| MH&LD BCU-2223-17 | 205 | PADR Compliance and WARRN training. | Reasonable | High | <p>Partially closed</p> <p>Evidence was provided of improvement in PADR compliance, however no data or evidence was provided for WARRN training compliance across the division, nor was there evidence of this data being reported / reviewed.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Data re WARRN training compliance - Regular reporting on compliance data |
| | 208 | Ockenden Recommendations. | | High | <p>Closed</p> <p>A recruitment and retention plan was provided, along with a Just R recruitment campaign impact support update to the MHL D senior leadership team.</p> |
| Audit Wales CHC Follow up BCU-2223-21 | 211 | Governance, accountability and performance. | Reasonable | High | <p>Outstanding</p> <p>Whilst narrative was provided on the governance arrangements, the evidence referred to was not attached.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|---|---------------|-------------------------|---|
| | | | | | To close the action, the following needs to be evidenced: <ul style="list-style-type: none"> - Structure chart - ToRs outlining reporting requirements etc. |
| Digital Strategy BCU-2223-22 | 212 | Funding the implementation of the Digital Strategy. | Reasonable | High | Closed The narrative updated by the Director of Digital states there is no funding available to support the Digital Strategy. The action has been closed as the related risks have been reflected on the risk register. |
| Public Health – Smoke free sites BCU-2223-28 | 219 | Policy not up to date. | Reasonable | High | Closed The policy has been updated and is available on BetsiNet. |
| Financial Control – Receipting of goods and year end accruals BCU-2324-02 | 246 | Procurement guidance and training. | Reasonable | High | Outstanding Evidence provided is a link to the procurement training and feedback link. No details / evidence is provided of the numbers of staff who require training, how many have had training or forward training |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|------------------------------------|-------------------|----------------------|---------------|-------------------------|--|
| | | | | | <p>plans. The Financial Control Action Plan was referenced but no further information was included.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Data on training completion / compliance i.e. number of staff who require training / number completed etc - Forward training plans (as referenced) |
| Accounts Receivable BCU-2324-03 | 275 | Cash Deficit. | Reasonable | High | <p>Outstanding</p> <p>Narrative was provided however the only evidence provided was an email confirming a meeting would be taking place.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Updated Standard Operating Procedure |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|--|
| | | | | | <ul style="list-style-type: none"> - Evidence of review of variances by Finance |

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:

| | | |
|--|-------------------------------------|--|
|  | <p>Substantial assurance</p> | <p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected</p> |
|  | <p>Reasonable assurance</p> | <p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.</p> |
|  | <p>Limited assurance</p> | <p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.</p> |
|  | <p>No assurance</p> | <p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations</p> |

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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AUDIT COMMITTEE - AUDIT TRACKER

| ID | Committee | Internal Audit (IA)/ Wales Audit Office | Report Title | Year | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Update provided to 12/01/2024 Audit Committee | Action Owner | Final Approver | Recommendation State | Original implementation date | Revised implementation date | Number of Revisions | Recommendation open or closed or pending |
|-----|------------------|---|--|------|-----------------|----------|--|---|--|---|---|--|-----------------------|------------------------------|-----------------------------|---------------------|--|
| 59 | Audit Committee | Internal Audit | Risk Management | 2022 | Reasonable | Medium | Strategic Objectives | The Health Board revisits its strategic priorities, setting objectives that are measurable by a set timeline. Further review of its completion to ensure aspects identified within the findings around risk appetite/target risk and controls etc. | The BAF continues to evolve with the engagement and support of the full Board. With the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' and all underpinning strategies, the Board will need to ensure a greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. This will be undertaken during the course of the year, ensuring that clearly articulated and measurable objectives are set, for achievement within a specific timeline. A review of the risk appetite/target risk score was undertaken at a Board Workshop on 27th April and further review/refinement will continue linked to the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' as we move through the year. | The Executive Team and Committee members are sighted on the current version of the Board Assurance Framework which is aligned to Strategic Priorities in the Annual Plan and have taken the action to review the Health Board's Objectives. This work will start in Feb 24 and the Board Assurance Framework risks will be aligned to objectives. The Acting Board Secretary is proposing to close the action to reflect this update, but also to note that original action was 2022, and related to an earlier context, of which events have moved on. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 31/03/2022 | 30/03/2024 | 2 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 72 | PFIG | Internal Audit | Performance measure reporting to the Board – Accuracy of information | 2021 | Reasonable | Medium | Reporting Accuracy | Whilst we recognise that first issue above was likely the result of a typing error, management must ensure that all data reported is accurate. To ensure consistency and transparency, changes to reporting methodology should be noted in the report and communicated to the reader. | Information reported to the Board in the Quality and Performance (Q&P) reports is currently extracted from a number of different data sources. Narrative to support the data is a combination of analysis by the Divisional/Programme leads and Performance Team Heads of Performance and Director of Performance. The current process is labour intensive and time consuming, the time between data being available and deadlines for producing the reports/completing the necessary internal governance clearance significantly limits the ability of the Performance Team to undertake quality assurance both in relation to the accuracy of the data included in each report as well as consistency between reports over time. The Board has requested the development of a new Integrated Quality and Performance Report (IQPR), this presents an opportunity to address the issues that are curtailing QA processes as well as to improve the content of the reports to ensure that the needs of the Board and subcommittees are met. Changes proposed include: Rationalising and automating the process of data collation and reporting - This will be supported by a process map of the current arrangements, which will enable the Health Board Informatics Team to develop a single performance data set. The Performance Team will work with the system developers in Informatics to harness Business Intelligence software with the aim of automating production of the 'front end' Board and Public facing reports. Once completed this new process should release Performance Team capacity to undertake detailed analysis of the information moving from performance reporting to performance monitoring and management, and should also provide more time to complete QA checks. Clear methodology for identifying areas of concern - The intention is to implement an assurance and risk scoring system that can be applied to each key metric (national and local) as well as the actions/outcomes identified in the Health Board Annual Plan. This will highlight the areas of greatest risk and/or lowest assurance which need to be brought to the attention of the Board. Additions and removals of items reported - Level of risk and assurance will change over time as a result of external factors as well as action taken by the service. The new IQPR will require a more dynamic approach to the items reported. It is recognised that the reasons for additions/removal of items from the report need to be open and transparent. It is intended that the new IQPR and the current reports, which will need to continue until the new report is in place will include a section where additions, removals and reasons for these changes are recorded. With regards to the development of the new IQPR, a Board workshop session took place on 27th April 2021 to discuss requirements. A plan comprising report specification and timescale will be produced for consideration by the CEO, Chairman and Executive Team in June 2021. | Additional assurance and evidence provided for closure: The implementation of the Integrated Performance Framework and the Integrated Performance Reports are well underway, having met in October and November 2023. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2021 | 31/12/2022 | 5 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 111 | People Committee | Internal Audit | Impact Assessments | 2022 | Reasonable | Medium | Policies and Procedures | 1.1a Health Board to clarify and document requirements regarding other Impact Assessments, and ensure information is embedded or signposted in key Health Board policy documentation (e.g. OBS1 Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, and F017 Policy for Revenue Business Case Development), and is accessible and visible to staff developing proposals / policies. Consideration should be given to an intranet page with the relevant resources and expertise signposted for staff. 1.1b Health Board to consider progressing and developing the Impact Assessment Gateway document for strategic and policy decisions including written control documents and development proposals to ensure statutory requirements are met. | The Office of the Board Secretary will review, develop and implement the Impact Assessment Screening Tool (IAST) in consultation with colleagues in strategy and planning, Equalities and other supporting functions. This review will take account of proportionality, recognising that some Impact Assessments are mandatory, some are of a technical nature (e.g. environmental impact assessments) and some are best practice. The review will also consider impact assessments that may become mandatory in the near future, such as the Health Impact Assessment, as well as being mindful of the principles of sustainable development contained within the Wellbeing of Future Generations Act. The review will also be further informed by the report of the Audit Wales review of Equality Impact Assessments across the Welsh public sector which commenced in October 2021 and for which the report is due in summer 2022. Once complete, associated key policies/documentation (Policy on Policies, Policy for Revenue Business Case Development etc.) will be updated to link back to the tool. The IAST will be uploaded to the Health Board's Policies and Procedures page on the staff intranet and can be linked back to from other key sites. The document will be subject to Health Board wide consultation (via the corporate bulletin, 'Draft documents for consultation intranet page' and targeted comms) and signed off by the Executive team. | The tool is available on the Policies page on sharepoint and signposted to on the EqIA pages. A full review of how the tool has been taken up will need to be undertaken through the IHC People and Culture meetings and will form part of the Equality Maturity Matrix self-assessments scheduled for early 2024. | Ceri Harris, Head of Equality and Diversity | Jason Brannan, Deputy Director of People | Final Client approved | 31/10/2022 | 31/03/2024 | 2 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 120 | PFIG | Internal Audit | Budgetary Control and Financial Reporting, including COVID-19 financial governance | 2021 | Reasonable | Medium | Authorised Virements | Finance to ensure that effective manual processes are in place to ensure segregation of duties are being adhered to, including regular sampling of virements. | 1) E-mail the Divisional Finance Teams to remind them of the importance of following due processes, with the process notes attached for information. (This action has already been carried out). 2) Sample 10% of virements on a month basis to test segregation of duties and authorisation of virements, calling CFO to account for any Breaches within their team. | Additional assurance and evidence provided for closure on sampling. | Michelle Jones, Head of Financial Reporting | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 25/06/2022 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 121 | PFIG | Internal Audit | Budgetary Control and Financial Reporting, including COVID-19 financial governance | 2021 | Reasonable | Low | Questionnaire responses | Finance to review the findings of the audit questionnaire, and complete the planned rollout of divisional questionnaires commencing March 2022. | 1) Finance to review the findings of the audit questionnaire and take on board any feedback. 2) Process for Divisional questionnaires to be sent out March 2022 onwards. This to be via a rolling process of 2 Divisions per month with a sample of 10-20 budget holders per Division. Feedback will be considered and steps taken to address any necessary actions which arise. (Questionnaires have been sent to a sample of budget holders in MH&LD & NWH Division in March and responses are currently being received and co-ordinated). | Questionnaire feedback supplied for additional assurance and evidence provided for closure | Michelle Jones, Head of Financial Reporting | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 24/06/2022 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 165 | PFIG | Internal Audit | Waste Management | 2022 | Reasonable | Medium | Non-compliance with Covid-19 operating procedure | Recommendations agreed to increase compliance with the Covid-19 SOP should be progressed and reviewed regularly to ensure implementation. | Estates and Facilities will continue with support from Senior Infection Prevention Leads, to increase compliance with the Covid-19 Standard Operating Procedure which will be reported through Infection Prevention Sub-Group. | Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August Compliance with the COVID19 SOP has now been achieved with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE. November update: Meetings have now been held with the IHC's and areas with plans put in place and waste audit's carried out on three sites including central IHC, Mold and Bryn Beryl. Additional evidence of closure provided. | Richard Daniel, Interim Director Capital and Estates | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/08/2022 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 167 | People Committee | Internal Audit | Speak out Safely | 2022 | Reasonable | Medium | MDT Process log | 1.1a Dates to be added into progress log i.e. 'date recorded' 'date of review' to enable tracking of concerns to outcomes. 1.1b Attendance at MDT meetings to be recorded to demonstrate meetings are accurate | 1.1a To add in details of recommendations in 1.1a into the MDT process log (process log updated and provided for reference). 1.1b Full names of attendees at MDT meetings will be captured on the process log (process log updated and provided for reference) | A record of the 'date recorded' and 'date of review' and also that attendance at meetings are logged. Additional evidence of closure provided. | Gareth Evans, Senior Organisational Development Manager | Jason Brannan, Deputy Director of People | Final Client approved | 30/11/2022 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |

| | | | | | | | | | | | | | | | | | |
|-----|------------------|--------------------|--|------|-------------|--------|---|---|---|--|---|---|-----------------------|------------|------------|----|--|
| 189 | Audit Committee | Internal Audit | Chairs action | 2022 | Reasonable | Medium | Information provided to members / committees | All Board/Committee members should have access to the information provided with the request to ensure transparency and further scrutiny. | Investigate a SharePoint site for Chair's Actions which will enable all Chair's Actions to be reviewed by all IMs should they wish to do so. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The reason why this has been marked as complete is that the corporate governance report now contains a routine capture of all Chair's Actions. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | Final Client approved | 31/01/2023 | 29/02/2024 | 1 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 204 | PFIG | Internal Audit | Management of Utilities | 2022 | Substantial | Medium | Health Board EFPMS performance | Management to identify what actions are required to reduce consumption in the sites identified in order to meet the all Wales KPI for net energy consumption. Where actions are already planned i.e. as part of the Decarbonisation Energy plan, this should be clearly stated | Operational Estates are working in partnership with Local Partnerships, Welsh Government Energy Services and Re-Fit Cymru in developing a framework to deliver the Health Board's Decarbonisation Action Plan relevant to Buildings. The framework will look at opportunity to invest in self generating energy sources i.e. Solar PV and energy reduction project by upgrading existing engineering infrastructure i.e. LED Lighting, HVAC etc. The project will be delivered over 2 phases with an estimated completion date for the framework by 2030. | The paper had been ratified and agreed at PFIG. Additional evidence provided, and action can be closed. | Arwel Hughes, Head of Operational Estates - Interim | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/06/2023 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 209 | PFIG | Wales Audit Office | Audit Wales CHC follow-up | 2022 | Reasonable | Medium | Continuing Health Care (CHC) Training Programme | The CHC Team, working with colleagues in Health Communities/Divisions/Pan-North Wales services agree a method to capture training needs analysis information upon which directed training can be planned and delivered. | Complete Learning Needs Analysis to identify training requirements and support the basis for planning further training activities, education approaches and methods; Learning Needs Analysis will expand on the Education Strategy and be coordinated through the CHC Strategic Joint Education Group (with LA partners). Mapping of training will capture relating framework, such as 117 aftercare. Innovative approaches to be considered and agreed (for CHC and Broadcare training) include multi-choice quizzes at the end of training modules, training videos, online feedback, Webinars, BetsiNet Newsfeed; continue to work with ESR to further develop accessible electronic CHC training modules; Improved data collection through group discussions, training needs assessment questionnaires/rolling review of feedback forms and surveys, skills and knowledge analysis, observations from lessons learned; Develop CHC Competency Framework by end of March 2023 with ambition to implement summer of 2023. CHC covers a diverse and specialised range of skills and the Framework will identify skills and knowledge required; Explore training appraisals within PADR and make recommendations to the operational teams for implementation. Implement training module to communicate Lessons Learned from Appeals and Retrospective Claims to the wider Health and Social Care system; coordinate through the CHC Strategic Joint Education Group; Share training attendance registers with operational line managers across the wider Health Board to address any issues of non-attendance and develop an action plan; Embed CHC Foundation module into core 'business as usual' training as part of the 2023 rolling training programme; the Foundation module will be delivered on a monthly basis from January 2023 and publicised via the BetsiNet CHC page and via the CHC Strategic Joint Education Group. | Confirmation that this item has been signed off following implementation of above listed actions. This item has also been signed off as a previous corporate risk. This recommendation can therefore be closed. | Jane Trowman, Head of Strategy and Health Planning | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/03/2023 | 01/09/2023 | 1 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 221 | Audit Committee | Wales Audit Office | Audit Wales Follow up - counter fraud | 2022 | Reasonable | Low | Recommendation 2 Resources and Skills | The Executive Director of Finance reviews succession planning and service continuity arrangements in line with the Audit Wales report, factoring in other NHS Wales comparators. | The Executive Director of Finance and the Finance Director: Operational Finance have reviewed the structure of the department with the Head of NHS Counter Fraud Wales including benchmarking both the amount of resource and the structure with other Health Boards across Wales. This process will continue to be monitored with the Head of NHS Counter Fraud Wales and all options will be considered for the most appropriate structure and resourcing of the department. | Re-banding of Deputy Head of Counter Fraud post accepted and submitted to payroll. Paper on future services presented through the Executive Directors of Finance All Wales meeting, and copy provided as additional evidence. | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 07/12/2022 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 222 | Audit Committee | Wales Audit Office | Audit Wales Follow up - counter fraud | 2022 | Reasonable | Medium | Recommendation 2 - Fraud Risks | Current ownership of fraud risks is reviewed and transferred for operational management and control where appropriate. The Counter Fraud Team works in partnership with the Risk Management Department to embed operational services ownership and identification of fraud risk in their day-to-day processes and any risks specific to the Counter Fraud team are reviewed on a regular basis. | The Director of Finance: Operational Finance has directed the Head of the Health Board's Local Counter Fraud Service to work with the Associate Director of Governance to agree the Agreed Management Action. Whilst the actions have individual action owners, the Associate Director of Governance will take responsibility to make sure they have been completed. Discussions have taken place with the Associate Director of Governance during November 2022 and have initially focused on the Management Actions which are required to be undertaken, to mitigate the Counter Fraud risks, to an acceptable level to achieve the Target Risk score - to allow the risks to be closed on the Risk Management system. The Associate Director of Governance will be tabling this at the BCUHB Risk Management Agenda Item in the BCUHB Health Board Leadership Team in January 2023 and the Risk Management Group in February to check and confirm that all actions have been taken. Associate Director of Governance to formally report to Audit Committee on a quarterly basis on the number of Fraud Risks which are being recorded by each of the Health Boards operational service departments. | This action can be closed. The Risk Management Group met on 5th June 2024 and this agenda item was on the agenda. Regular meetings take place with both the Board Secretary and the Head of Risk Management. Counter Fraud is to be added to the cycle of business for RMG annually and a report was presented at RMG where it was noted the Fraud Risk Register needed to be updated, working with the risk team will now be business as usual. Additional evidence provided to support closure. | Phil Meakin, Associate Director of Governance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/12/2022 | 06/12/2023 | 2 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 225 | PFIG | Wales Audit Office | Audit Wales Structured Assessment 2020 | 2020 | N/A | High | R3 | Reporting progress against delivery of plans: Ensure that outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes. | The plan for quarters 3 and 4 is stronger on outcomes at a programme level than previous quarterly plans. Our chosen outcomes tie back to Living Healthier Staying Well and national outcome frameworks. Performance trajectories are also being developed for this planning round. In respect of reporting against performance, through direct engagement with operational leads, we are strengthening the narratives required for actions that are off track. Furthermore, we are looking at triangulation with the performance measures outlined in the NHS Wales Delivery Framework and how plan outcomes are impacting upon these. | IPR has now been agreed by the board and is being use in Health Board meetings. Additional evidence provided for closure | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/11/2020 | 31/12/2022 | 6 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 228 | PFIG | Internal Audit | Continuing Healthcare Arrangements | 2020 | N/A | High | R8 | While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management. | A transition plan has been agreed to consolidate the corporate CHC leadership team. This team will now oversee CHC and the care home sector reporting into a substantive Assistant Director of Primary and Community services from 1 January 2021. | Confirmation was given by the Executive Director Transformation and Strategic Planning that he will remain the executive lead for Corporate CHC subject to any later/further review of Executive portfolios. An Acting Assistant Director for Care Homes and CHC Commissioning has been appointed, which has been extended to December 2024 to ensure continuity and leadership for the corporate team. | Kathryn Titchen, Commissioning Manager CHC | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/01/2021 | 07/03/2023 | 9 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 243 | QSE | Internal Audit | Managing Medicines in Primary and Secondary Care | 2016 | N/A | High | R1 | The Welsh Government, NHS Wales Informatics Service and all health bodies should agree a detailed, time bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery plan. | The NHS Wales Informatics Service (NWIS) has established the Welsh Hospital Electronic Prescribing and Medicines Administration (WHEPMA) project to develop and implement the national plan for electronic prescribing in secondary care and the inaugural meeting of the project board was held on 23 November 2016. The project team is currently working with stake holders to define the exact scope of the project and the system requirements. Once this is complete the business case for procurement of a replacement hospital pharmacy system and an electronic prescribing and medicines administration solution will be completed by NWIS and considered by Welsh Government. Subject to the completion of the business case, it is expected that the procurement of these systems will be completed during 2018-19 with implementation beginning in the early part of 2019. Identify a BCU representative for the national project board and a medical, nursing and pharmacy link for the project by April 2017. National project to present the strategic outline business case to QSG/EMG by June 2017 prior to submission to WG. Establish a BCU implementation group by September 2017. | Evidence of Terms of Reference and notes of August health board programme board meeting (October note not yet available), and National Secondary Care programme board highlight report provided as additional evidence. 1. Electronic Prescribing and Medicines Administration (ePMA) Programme Board established (ToR and notes of recent meeting) 2. Senior Responsible Officer (SRO) and Programme Board chaired by Deputy Executive Director of Nursing and Midwifery. 3. Pre-implementation plan and programme milestones agreed by the Digital Transformation Medicines Portfolio and Welsh Government ePMA national board. 4. Health Board Business Case mid-drafting (November 2023) Additional Evidence Supports closure. | Lois Lloyd, Interim Chief Pharmacist | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2017 | 31/01/2024 | 16 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 271 | People Committee | Internal Audit | Recruitment Improvement Review | 2023 | Substantial | High | Published documents | Management to ensure all published documents and guidance notes are relevant, up to date, and reflect current practice/requirements. | All BetsiNet pages that contain information and guidance on the recruitment process will be reviewed and updated, and any documents which are no longer relevant will be archived. | As identified in the audit, the recruiting managers guides on BetsiNet have been updated as per the new employment checks process implemented in September 2022 - additional evidence provided to support. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/06/2023 | 30/03/2024 | 1 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
| 272 | People Committee | Internal Audit | Recruitment Improvement Review | 2023 | Substantial | High | Board and Committee reporting | Management to review governance and reporting arrangements to ensure implementation and performance is subject to Health Board review and scrutiny. | A set of recruitment KPIs that can easily identify the Health Board's performance against target time-to-hire timeframes relating to Manager, NWSSP and People Services lines of responsibility, which can also be benchmarked against other Health Boards in Wales, will be included in the workforce performance report that is provided to PFIG committee. This will be supported with contextual information as to actions and issues relating to sustaining acceptable recruitment performance. Moreover, it is expected that the existing workforce BI dashboards, which contain relevant recruitment KPIs, will be utilised in local IHC reporting and oversight. | The KPIs have been approved by PFIG and have been in place since July 2023, and additional evidence has been provided to support this. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/06/2023 | | 0 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |

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|-----|------|----------------|----------------|------|-------------|------|-------------|---|---|---|---|--|-----------------------|------------|------------|---|--|
| 274 | PFIG | Internal Audit | Cyber Security | 2023 | Substantial | High | Use of KPIs | KPIs should be developed that show the current security posture of the organisation | As noted in the report, the Cyber Security and Compliance Team have begun a piece of work to develop proposals for KPI's taking into consideration work being carried out nationally. The proposals will be developed ASAP, presented to the CDIO for implementation consideration by the end of Q3, 2023/24. | The Chief Digital Information Officer has approved the set of Cyber Security Key Performance Indicators, which take into account the requirements of the Network and Information Systems Regulations 2018 will now be implemented and reporting through the standardised governance arrangements via the ICT Security and Governance Group, which reports into the Information Governance Group and then upwards to the Performance, Finance and Information Governance Committee. (This reporting may revert to the Partnerships, People and Population Health Committee when meetings re-commence). Additional evidence to support closure provided | Sion Jones, Assistant Director/Chief Technology Officer | Dylan Roberts, Chief Digital and Information Officer | Final Client approved | 01/09/2023 | 30/11/2023 | 1 | Approved for closure at 12/01/2024 AC - will not be reviewed by IA |
|-----|------|----------------|----------------|------|-------------|------|-------------|---|---|---|---|--|-----------------------|------------|------------|---|--|

AUDIT COMMITTEE - AUDIT TRACKER

| ID | Committee | Internal Audit (IA)/ Wales Audit Office | Report Title | Year | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Update provided to 12/01/2024 Audit Committee | Action Owner | Final Approver | Recommendation State | Original implementation date | Revised implementation date | Number of Revisions | Recommendation open or closed or pending |
|-----|------------------|---|--|------|-----------------|----------|--|--|--|---|---|---|-----------------------|------------------------------|-----------------------------|---------------------|--|
| 127 | QSE | Internal Audit | Clinical Audit | 2022 | Limited | Medium | Policy and process in place for clinical audit. | Review and update the policy and procedure document MD22, and include the governance structure within Appendix 1. | Management comment: Awaiting release of final operating model. The updated policy has been held in draft form, since September 2021, awaiting confirmation of the new organisation operating model and associated governance structures. The governance that underpins the new operating model, directly impacts on the roles and responsibilities embedded within the policy as well as providing necessary operational detail (included within the appendices). Agreed action - Subject to confirmation of the new operating model (and governance structure) in April 2022, the audit policy will be released for Health Board wide consultation May 2022, with view to agreement through Clinical Policies and Procedures Group (CPPG) / Clinical Effectiveness Group (CEG)/ Quality, Safety and Clinical Effectiveness (QSE) by September to accommodate Cycle of Business of these groups. The reviewed policy will outline all processes and current practice in relation to clinical audit activity within BCUHB and will reinforce its role within the quality framework in delivering quality improvement and quality control and will be formally communicated to staff. | The Clinical Audit Policy has now been completed and ratified and uploaded on to the intranet after going through the relevant processes. The policy is on the Clinical Effectiveness page and promoted by the team each month in Local CEG meetings. We will be adopting of sharing direct to the IHC MDs on a monthly basis copying in HofCE and DEMD. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2022 | 30/04/2023 | 5 | Closed - approved by IA |
| 170 | QSE | Internal Audit | Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website | 2022 | Limited | High | 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 the English website. | 2.1a In response to recommendations 1.1, 1.2 and 1.3 recommendations have been made to resolve the current risk of non-compliance. These include: Establish a formal policy and guidance to support the management of BCU digital channels, including the website. Review current administration access to the BCU website and issue revised guidance and training where required. Recruit a dedicated translator for the Corporate Communications Team to manage all translation requests for the website, which will ensure content is published simultaneously and ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. 2.1b Issues identified with the audited web pages that are managed by the Corporate Communications Team have been resolved. 2.1b Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website. 2.1b Establish a regular programme of audits with the Welsh Language Team to monitor the website on a monthly basis. 2.1b The Board Secretary to review and resolve issues relating to the publication of inconsistent Board/Committee papers and bundles. | The support from the external company is now complete, and this concludes the actions relating to this recommendation. The draft report has been received back from the Auditors to confirm all actions have been completed and no further actions is required. This recommendation can now be closed. | Andrew Rogers, Head of Corporate Communications | Teresa Owen, Executive Director of Public Health | Final Client approved | 31/12/2022 | 30/09/2023 | 3 | Closed - approved by IA |
| 199 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | High | 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. | 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. | Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required, and further information provided as evidence. | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/01/2023 | | 0 | Closed - approved by IA |
| 202 | PFIG | Internal Audit | Delivery of Health Board Savings | 2023 | Limited | High | Effective governance and oversight arrangements to deliver savings | The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes. | The targeted delivery of operational savings has been progressed within the Health Board and delivered for the 2023/24 financial year. | Further evidence relating to BCU savings reporting provided as assurance for closure. | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 30/04/2023 | | 0 | Closed - approved by IA |
| 208 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | Medium | Ockenden Recommendations | Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to address the vacancies within the division and ensure stability of the management. | Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and any additional intervention discussed and agreed for areas with high number of vacancies. Divisional Accountability meetings with each area to be stood up to support the additional scrutiny and interventions required to vacancy position, recruitment processes and accuracy of data. Provide ongoing progress of the Just R Marketing campaign within the MH&LD Staff Briefing. Discussion of monthly Divisional Vacancy and Recruitment report at MH&LD Service People and Culture Delivery Group meeting. On-going progress with Just R Marketing campaign, talent pool process and further development of innovative approaches to address the number of vacancies across the Division. Creation of Quarterly report which will be presented at Operational Leadership Meeting (OLM) feeding into MH&LD Senior Leadership Team meeting to show impact and outcomes of the Just R Marketing campaign, to discuss and agree any further plans to address current vacancies across the Division. Ongoing progress and delivery of actions included in the Wellness, Work and Us Year 3 plan aligned to staff recruitment and retention, with creation of 36 month report to show impact, outcomes and recommendations aligned to addressing staff recruitment and retention. Continued monitor and review of Workforce work stream programme plan, recording and reporting impacts and outcomes of delivery. Development of a MH&LD Recruitment and Retention Strategy to ensure short, medium and long term focus on workforce recruitment and retention across all staff group within the Division. Review of all interim posts across the Division. Discuss and agree a plan to progress with substantive appointment to posts aligned to the MH&LD Operating Model. | MH&LD Divisional Recruitment and Retention plan developed and approved through respective Governance routes (copy provided for evidence). This ensure the Division has a clear recruitment plan in place to addresses the vacancies within the division. Just R 12 month recruitment plan ended September 2023 with transition plan agreed for utilising BCHUB External website and Social Media to continue showcasing the Division with the inclusion of microsite, live vacancies and talent pool vacancies. This provides a mechanism to support recruitment activities, as is part of the MH&LD Divisional Recruitment and Retention plan. Impact report on the Just R Campaign to evidence return on investment presented at the MH&LD Service, People and Culture Group meeting, and additional evidence provided. | Adrienne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MHL | Final Client approved | 30/06/2023 | | 0 | Closed - approved by IA |
| 212 | PFIG | Internal Audit | Digital strategy | 2023 | Reasonable | High | Funding the implementation of the Digital Strategy | The Chief Digital and Information Officer, working with Finance colleagues: <ul style="list-style-type: none"> identifies the costs associated in implementing the digital strategy. ensures the budget report accurately reflects the funded establishment. where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee. | Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPH that includes the details about unfunded projects and the risks association with stopping those. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24. | The Chief Digital Information Officer has accepted this position as the Health Board are tolerating the risk which has been escalated to the Board and accepted. There is nothing further the Digital, Data and Technology Division can do to address this recommendation due to the Health Board's decision making in the current financial climate. Digital, Data and Technology Division will continue to put forward for all available funding in future years. Additional evidence provided for closure. | Andrea Williams, Head of Informatics Programmes Assurance and Improvement | Dylan Roberts, Chief Digital and Information Officer | Final Client approved | 30/06/2023 | | 0 | Closed - approved by IA |
| 219 | QSE | Internal Audit | Public Health - Smoke free sites | 2023 | Reasonable | High | Policy not up to date | Smoke free policy WP31 is progressed and agreed through the appropriate process as a matter of urgency to become compliant with legislation | Receive confirmation from the Board regarding position of smoking shelters across BCUHB in relation to legislation. Feedback to the WOD policy group on acknowledgment of their concerns and our position in line with legislation/ board decision and sign off. Once approved, submit policy to relevant approval groups for ratification. Once ratified, develop communications plan to promote revised policy across the organisation and add to BetsiNet policy pages. On-going review of management plan to ensure policy has been implemented. Review policy for any amendments regarding enforcement/compliance that develop throughout the year. Ensure BCUHB Smoke free Policy links with further policy development across each of the 3 acute hospital sites to support compliance with smoke-free legislation (including due diligence and reasonable steps). To include working with IHC's and Hospital Leads on developing, implementing and monitoring smoke-free hospital plans that support the wider BCUHB smoke free policy. | A considerable amount of work is ongoing in relation to review and engagement, and this forms part of the plan to work with the IHCs on the longer term management of the policy. Additional evidence provided to support closure. | Gavin Jones, Health Intervention Co-ordinator | Teresa Owen, Health Board Lead for MHL and Welsh Language | Final Client approved | 31/10/2023 | | 0 | Closed - approved by IA |
| 248 | People Committee | Internal Audit | Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 2023 | Limited | High | Standing Orders Compliance | The engagement of all interim/agency appointments must comply with the Standing Orders, Standing Financial Instructions and associated Delegated Matters/Scheme of Delegation and Standard Operating Procedure. Issues of non-compliance must be included in all relevant Performance and Accountability meetings with clear actions Minuted and officers held accountable for continual non-compliance. | 2.1a A recent revision to the standard operating procedure F18, senior nonclinical agency interim engagements (v11) now incorporates a maximum contract length of 4 month for every request. Similarly, the Executive Director of Finance is now a co-approver of all new interim requests. A further addition will be made that will require a full contract value calculation to be undertaken by the requesting manager upon submitting the IAR, which will be validated against their SFI limits. This will require the requestor to liaise with their finance CFO to accurately quantify the total cost of the interim engagement. 2.1b Non-compliance with WG required processes, Standing Orders and SFIs will be reported to RTS (quarterly) and PFIG (monthly). Repeated non-compliance with process, by a single department, will be escalated to audit committee; the parameters of which will be defined in the response to point 3 below. Upon requesting an interim worker for a VSM post, the IAR form will be updated so the requestor will be asked to confirm they have been in contact with WG head of profession. The recruitment team will ensure all VSM posts are communicated to the relevant WG leads before any appointment is confirmed. | The format and content of the senior interim report was approved in September 2023, with an excerpt from the August 23 REMCOM meeting provided as further evidence. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 31/06/2023 | | 0 | Closed - approved by IA |

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|-----|-----------------|----------------|--|------|---------|------|--|---|---|---|---|--|-----------------------|------------|------------|---|-------------------------|
| 250 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Risk Management department duties | The Strategy is updated to include the duties of the Risk Management Department. | The Risk Management Strategy to be revised to include the duties of the Risk Management Department. | The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23. Additional Evidence provided to support closure. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 28/09/2023 | 1 | Closed - approved by IA |
| 251 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Oversight, scrutiny and challenge of CRR and BAF | The Health Board must ensure meetings within the governance structure take place as required, to allow adequate review and scrutiny of the risks facing the Health Board. Clarification is required on how often the Health Board and Audit Committee receive the CRR and BAF for review and scrutiny. | Review of the CRR review frequency (RM Strategy), within the Board and committee structure. The Health Board and Audit Committee to have a Cycle of Business to include the CRR and BAF for review and scrutiny (additional IA comments to the Management Response - We note the management action to consider where the CRR is reviewed, however management need to ensure these meetings take place to ensure sufficient scrutiny of the CRR). | The revised RM01 details cycle of business for Board Assurance Framework and Corporate Risk Register and was approved at September Board 2023. All cycle of business for committees/Board also reflect this change. Additional Evidence provided to support closure. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 31/09/2023 | 1 | Closed - approved by IA |
| 253 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Escalation and de-escalation of risks | Clarification is required on the Committee approval process for the escalation and de-escalation of risks. | Review of the RM02 v3.9 to indicate the QSE approves the escalation/de-escalation of risks. | The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the Board Assurance Framework and Corporate Risk Register are a standing agenda item on bi-monthly basis as well as risks to be escalated/de-escalated. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | Final Client approved | 30/08/2023 | 31/10/2023 | 1 | Closed - approved by IA |
| 266 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | High | Performance report and measures | The Health Board continue with the improvement plan to review and update the quality performance report to ensure Committees are receiving appropriate, accurate and relevant information. This should assurance mechanisms in place through Board Committees, to ensure the Health Board are sighted on key areas of concern and are provided with assurance that Committees are considering all areas of performance. | The Health Board is reviewing its governance/assurance structures in line with Special Measures – this includes looking at the oversight / performance frameworks and associated reporting, processes and documentation. This will involve the gradual 'integration' of reporting on operational delivery, quality, safety and patient experience, workforce and finance by the end of March 2024. Alongside this includes a Review of the content, editorial ownership and quality of the information and data contained within all performance reporting it. This includes work with Informatics to ensure all Operating Framework Metrics, trajectories and other KPIs included in the Board Report have a documented processes and signoff for submission nationally, locally etc. Closer editorial management of the Performance Report now sits with the Director of Performance role. Effective Feb 2023 a summary/highlight report has been introduced to direct reviewers to key points of variation and from June 23 includes NHS Wales published Organisation Performance Reports and where relevant/available the comparative performance across all Wales' Board. Work continues alongside the revision of the Performance and Accountability Framework. | The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25/10/2023. This iteration will be presented at Performance, Finance and Information Governance Committee on 02/11/2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before its inaugural presentation at Health Board on 30/11/2023. Action complete, with the Health Board receiving at the meeting of the 1st December 2023 the Integrated Performance Report. However, continuous development and refinement of the report will continue. Additional evidence for closure provided. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/03/2024 | | 0 | Closed - approved by IA |
| 278 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Clinical Audit participation | The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits. | On the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August a request was made that each local CEG discuss and identify resource gaps and how they come to that conclusion and bring back to CEG 12th September meeting relevant information for us to capture in Chairs Report to escalate to relevant Health Board meetings. | There is a process in place that concerns with resources for Tier 1 audits need to be brought to Strategic Clinical Effectiveness Group with what has been reviewed with regard to resources, that all options have been exhausted and the need to raise for support. Tier 1 is mandatory and it has been made clear that means BCUHB needs to be participating in these audits and making every attempt to do so. The Chair's report from SCEG will include details that need to be escalated to Quality Delivery Group if further support is needed to address this. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | Closed - approved by IA |
| 279 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Validation of Data | Clinical Effectiveness Department liaise with the services to establish how the data is validated for each audit, this will enable the department to gain a better understanding of how the data is collected and validated. | Team are non-clinical and would not be able to validate this. At the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August we will request that when each Tier 1 audit is published that the area will need to validate how the data was collected. This will provide assurance and we can capture within our minutes and quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note. | Team are non-clinical and would not be able to validate this as each Tier 1 audit is published they will request detail from the area to validate how the data was collected. This will provide assurance and we can capture within quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note. The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead to identify what validation takes place prior to data submission. This is being recorded on the departmental database and part of our team process to ensure we have all relevant information for reporting to Strategic CEG, QDG and QSE to provide assurance and if there are queries raised that escalation of this is followed. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | Closed - approved by IA |
| 281 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Progress reporting of Tier 1 audits (b) | To enhance accessibility of audit activity, improve timely reporting and keep track of the identified actions, the AMaT system needs to be developed further outside of the department and continue to be implemented throughout the Health Board. | We do currently update AMaT with all Tier 1 information and add on action plans however we need to review if beneficial to be using outside of department. Will look at piloting within couple of Tier 1 areas for feedback at relevant meetings. | All Tier 1 audit publications are uploaded onto AMaT (Audit Management and Tracking Software) as they happen and details and details entered into the Service Assessment form which note assurance/risk/level or actions to follow. The Audit webpage has information regarding the progress with the expected Service Assessment form and any approved forms are uploaded on to the system. All details are uploaded on to the webpage and it is being promoted regularly. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/12/2023 | | 0 | Closed - approved by IA |

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|-----|-----|----------------|---|------|---------|------|--------------------------|--|---|--|---|--|-----------------------|------------|--|---|-------------------------|
| 283 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Learning from audits (b) | Clinical Audit updates/Annual Clinical Audit Report to be presented to the Quality and Safety Committee to allow Health Board members the opportunity to challenge and approve the documents. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in CEG and QDG so has mechanism in place to escalate when necessary. | All papers are on Cycle of Business (COB) and when to be presented at relevant meetings. As the QSE has stood down on a number of occasions, after being submitted at the Strategic Clinical Effectiveness Meeting, papers have been submitted at Quality Delivery Group for submitting in August. They will then go to QSE and Audit Committee now that dates have been re-established and agenda confirmed. | When reviewing the Cycle of Business for Strategic CEG, we took into account when the quarterly reports would be presented, at Strategic Clinical Effectiveness Group and then to Quality Delivery Group within our Chair's Report. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in Strategic CEG and QDG so has mechanism in place to escalate when necessary. We constantly monitor our processes within the team to improve as necessary. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 30/09/2023 | | 0 | Closed - approved by IA |
| 305 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section. | 4.1b Action 2 - The Health Board Patient Safety team will provide a weekly report from Datix of the previous weeks closed incidents to monitor quality of completion to be sent to IHC Directors of Nursing and IHC Governance leads to action locally this will be an ongoing process. | The Patient Safety Team provide a weekly report to IHCs/divisions that identifies incidents reported as moderate and above harm that have been closed without a management review/investigation or have gaps in lessons learned or have not followed process. These are re-opened by the Patient Safety Team and communication sent to the person who closed it and the governance lead. A monthly report is also sent for none and low severity incidents that have been closed without a management review. Additional evidence for closure provided. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | | | 0 | Closed - approved by IA |

Follow Up of audit recommendations – January 2024 Audit Committee Internal Audit Report

March 2024

Betsi Cadwaladr University Health Board



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CYMRU
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Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
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Bwrdd Iechyd Prifysgol
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University Health Board



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|-------------------------------|--|
| Review reference: | BCU-2324-22a |
| Report status: | Internal Audit Report |
| Fieldwork commencement: | 26 February 2024 |
| Fieldwork completion: | 29 February 2024 |
| Draft report issued: | 29 February 2024 |
| Management response received: | Not Applicable |
| Final report issued: | 26 March 2024 |
| Auditors: | Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit |
| Executive sign-off: | Phil Meakin, Interim Board Secretary |
| Distribution: | Nesta Collingridge, Head of Risk Management Glesni Driver, Head of Covid 10 Inquiry |
| Committee: | Audit Committee |



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

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

Disclaimer notice - please note:

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

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

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

Executive Summary

Purpose

To review the evidence received by the Office of the Board Secretary to support closure of a number of audit actions from various audit reports, as requested at the January 2024 Audit Committee.

Overview of findings

Of the 31 actions reviewed, there was sufficient evidence available to support the closure of 17 actions.

We consider 6 actions to be partially closed, where some evidence has been provided but this does not demonstrate full completion of the agreed action.

We consider 8 actions to be outstanding, where either no evidence was provided, or the evidence provided was not sufficient to support closure of the actions.

Recommendations / agreed actions plans where the evidence is not sufficient and further evidence is required to close, are from the following reports:

- Integrated Service Board Governance
- Charitable Funds
- Recruitment of Substantive and Interim Executive and Senior Posts (ESP)
- Performance Management – Quality and Performance Reporting and Accountability Arrangements
- Clinical Audit – Tier 1 National Audits
- Falls Management
- MH&LD
- Audit Wales CHC Follow up
- Financial Control – Receipting of goods and year end accruals
- Accounts Receivable

Assurance summary

| | High | Medium | Total |
|------------------|-----------|----------|-----------|
| Closed | 12 | 5 | 17 |
| Partially closed | 5 | 1 | 6 |
| Outstanding | 7 | 1 | 8 |
| Total | 24 | 7 | 24 |

1. Introduction

1.1 The value of internal audit reports lies not only in the opinions they contain but also in the opportunities for improvement, which they identify.

In making recommendations and agreeing action plans it is intended that improvements can be made both in internal controls and operational effectiveness. However, in order to ensure that the benefits of this process are achieved it is necessary to subsequently follow up the implementation of the agreed actions in order to assess:

- whether implementation has occurred or been superseded by further events; and
- whether the actions have produced the intended effect.

Follow up is, therefore, a vital element of any audit and it is our policy, in accordance with the audit plans, to revisit previous assignments.

1.2 The objective of this audit is to review the information and evidence received by the Office of the Board Secretary to support closure of actions. We have reviewed this information only and have not sought further evidence from management.

1.3 As per the Audit Charter, Audit & Assurance are required to follow up:

- All recommendations (High/Medium/Low) from Limited / No / Unsatisfactory assurance rated reports; and
- High recommendations from other reports (Substantial or Reasonable assurance rated reports).

1.4 The Office of the Board Secretary provided us with 49 actions. We have reviewed the evidence for 31 of these, in line with the requirements above:

| Type of action | Number of actions |
|--|--------------------------|
| High / Medium / Low actions from Limited reviews | 24 |
| High actions from Reasonable reviews | 7 |
| Medium/Low actions from Reasonable and Substantial reviews | 15 |
| Audit Wales reviews | 3 |
| TOTAL | 49 |

1.5 Of the thirty one (31) actions reviewed, we consider:

- 17 to be closed, with evidence to verify completion;
- 6 to be partially closed, with limited evidence to verify completion; and
- 8 to remain outstanding, with no or limited evidence to support closure.

1.6 For those actions partially closed or outstanding, we recommend the Office of the Board Secretary re-visit the action with the relevant owner to ensure there is evidence to support all agreed management actions. Where additional evidence is received, this will be reviewed and included in future reports.

Appendix A: Status of actions

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|--|-------------------|------------------------------|---------------|-------------------------|--|
| Integrated Service Boards BCU-2122-07 | 119 | ISB Governance arrangements. | Limited | High | <p>Outstanding</p> <p>We were provided with minutes of the Health Board where the updated Scheme of Reservation and Delegation was approved, however the SORD is not included, and this does not address the issues raised in the report re governance of the Integrated Service Boards, such as:</p> <ul style="list-style-type: none"> - Inconsistent Terms of Reference - No evidence of executive level oversight or scrutiny to ensure objectives and actions of the ISBs align with the Health Board - No regular updates received from ISBs to health board committees - Delegated authority re ISB participation is not stated in HB standing orders or scheme of reservation and delegation. |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|--|---------------|-------------------------|---|
| | | | | | <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Details of where there is oversight of ISBs and how this is reported via the Board - Consistent Terms of Reference for ISBs |
| Clinical Audit BCU-2122-13 | 127 | Policy and process in place for clinical audit. | Limited | Medium | <p>Closed</p> <p>The Clinical Audit Policy and Procedure has been updated and is available via BetsiNet.</p> |
| Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website BCU-2223-04 | 170 | Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43) | Limited | High | <p>Closed</p> <p>This review was subject to a full follow up review, where all actions were evidenced as complete.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|-------------------------------------|-------------------|------------------------------------|---------------|-------------------------|--|
| Charitable Funds BCU-2223-14 | 193 | Information provided to the Board. | Limited | High | <p>Outstanding</p> <p>Narrative is provided, however only evidence is link to charitable funds committee papers.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Copy of induction information provided to board members - Feedback received from trustees re frequency and content of information - How Trustees are provided with assurance that the requirements of the Charity Commission are being met, and how changes to requirements are communicated. |
| | 199 | Charity objectives. | | | High |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|--|---------------|-------------------------|---|
| Delivery of Health Board Savings BCU-2223-15 | 202 | Effective governance and oversight arrangements to deliver savings. | No | High | Closed This has been subject to a full follow up review and a new recommendation has been raised. |
| Recruitment of Substantive and Interim Executive and Senior Posts (ESP) BCU-2223-C32 | 248 | Standing Orders Compliance. | Limited | High | Closed Narrative is provided, however no evidence is provided to support this. However through our current work we have confirmed that this report is provided to the Committee and are content to close the action. |
| | 249 | Remuneration and Terms of Service Committee – Reports for assurance. | | High | Outstanding Narrative is provided, however no evidence is provided to support this. A governance report to the Health Board outlining chairs actions, common seal, Standing orders and proposal for BCUHB Committees and advisory groups was received. No evidence was received relating |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|--|-------------------|---|----------------|-------------------------|---|
| | | | | | <p>to reports to the Remuneration and Terms of Service Committee.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Remuneration and Terms of Service Committee terms of reference re reporting requirements - Regular reporting to the committee on JESP/VSM appointments. |
| <p>Risk Management and Board Assurance Framework BCU-2223-02</p> | <p>250</p> | <p>Risk Management Department duties.</p> | <p>Limited</p> | <p>Medium</p> | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However as part of the current review of Risk Management, RM01 is being reviewed and includes the duties of the Corporate Risk Team.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|---|---------------|-------------------------|---|
| | 251 | Oversight, scrutiny and challenge of CRR and BAF. | | High | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However, through our attendance at the Risk Management Group and other Committees, we can see regular oversight, scrutiny and challenge of the Risk Register.</p> <p>Whilst we have closed the action, we note that there is work ongoing to update the BAF, and are satisfied that this work is progressing sufficiently.</p> |
| | 253 | Escalation and de-escalation of risks. | | High | <p>Closed</p> <p>Narrative is provided, however no evidence is provided to support this.</p> <p>However, as we attend the Risk Management Group, the RM02 was presented which includes information on escalation and de-escalation of risks and where this sits for different categories and Tiers of risks.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|----------------------------------|---------------|-------------------------|--|
| Performance Management – Quality and Performance Reporting and Accountability Arrangements BCU-2223-26 | 266 | Performance report and measures. | Limited | Medium | <p>Closed</p> <p>A revised performance report was presented to the Health Board in December 2023. This includes a summary of escalated performance measures.</p> <p>It is recognised that this work is ongoing, however we consider sufficient progress has been made to date to close the action.</p> |
| | 269 | Accountability meetings (b). | | High | <p>Outstanding</p> <p>No revised action tracker received and no evidence of accountability meetings being undertaken.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Revised action tracker to confirm actions are reviewed regularly |
| Clinical Audit – Tier 1 National Audits | 277 | Clinical Audit Plan. | Limited | Medium | <p>Outstanding</p> <p>Narrative states the Clinical Audit Plan for 2023/24 went to the Quality Safety and Experience Committee in August 2023,</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|-------------------------------|---------------|-------------------------|---|
| BCU-2324-04 | | | | | <p>however no papers are attached. The published agenda for the August meeting does not include the Clinical Audit Plan for 2023/24.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Agenda and minutes confirming the Clinical Audit Plan for 2023/24 was presented and approved at the QSE Committee |
| | 278 | Clinical Audit Participation. | | | High |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|---|
| | | | Yellow | Red | <p><i>done and what other avenues have been looked at to deliver the audits. If issues remain then this can be escalated outside of SCEG (Strategic Clinical Effectiveness Group) as required.</i></p> <p>We consider this action closed, however have not confirmed current Tier 1 audit progress, or whether the escalation process has been required to be used.</p> |
| | 279 | Validation of Data. | | | Medium |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|--|---------------|-------------------------|---|
| | 280 | Progress reporting of Tier 1 audits (a). | | High | <p>Partially closed</p> <p>A draft Clinical Effectiveness Assurance report was received, however this had comments/changes included and it is not confirmed where this has been presented</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Assurance report presented to the relevant group /committee |
| | 281 | Progress reporting of Tier 1 audits (b). | | Medium | <p>Closed</p> <p>Information on the progress of Tier 1 audits is included on the Clinical Effectiveness intranet page (latest update is February 2024).</p> |
| | 282 | Learning from audits (a). | | Medium | <p>Partially closed</p> <p>Whilst an example of a completed form was provided, which states where learning was discussed, there was no evidence to support this i.e. papers / minutes.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---------------------------------|-------------------|---|---------------|-------------------------|--|
| | | | | | To close the action, the following needs to be evidenced: <ul style="list-style-type: none"> - Monthly update to IHCs - Quarterly reports - Example evidence i.e. completed form stating where findings were discussed and evidence to support this (papers / minutes / emails to staff etc.) |
| | 283 | Learning from audits (b). | | High | Closed Outcomes of audit reports are summarised in quarterly reports that are provided to QSE. |
| Falls Management BCU-2324-05 | 293 | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA)(a). | Limited | High | Partially closed The e-learning module has been updated and includes examples of good practice / how to complete documents. Whilst this is positive, there was no evidence provided to support review of compliance figures through the monthly falls steering group (as stated in update). |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|---|---------------|-------------------------|---|
| | | | | | <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Evidence of regular review of compliance with learning via the monthly falls steering group |
| | 297 | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA)(c). | | High | <p>Partially closed</p> <p>Guidance has been issued to reinforce the need to complete the risk assessment, however there was no evidence to support review of compliance figures, as stated in the recommendation /action.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Ward metrics to support monitoring / compliance with completion of FBHMA |
| | 302 | Training. | | High | <p>Partially Closed</p> <p>Training provided to Agency workers has been confirmed, and they now have access to the Health Board e-learning packages.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|---|
| | | | High | | <p>Agency staff are encouraged to complete these, and Agency worker induction documentation has been amended.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Agency worker induction documentation - Evidence of regular review of compliance re agency uptake of falls e-learning |
| | 305 | Governance. | | High | <p>Closed</p> <p>Evidence received that demonstrates a review of incidents reported as moderate and above harm that are closed without management review / investigation / lessons learned, which are then sent to IHCs to action.</p> <p><i>Note – whilst closed, we have only considered the central review of this information and not reviewed the outcome of any review by IHCs.</i></p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|--|-------------------|---|---------------|-------------------------|--|
| MH&LD BCU-2223-17 | 205 | PADR Compliance and WARRN training. | Reasonable | High | <p>Partially closed</p> <p>Evidence was provided of improvement in PADR compliance, however no data or evidence was provided for WARRN training compliance across the division, nor was there evidence of this data being reported / reviewed.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Data re WARRN training compliance - Regular reporting on compliance data |
| | 208 | Ockenden Recommendations. | | High | <p>Closed</p> <p>A recruitment and retention plan was provided, along with a Just R recruitment campaign impact support update to the MHL D senior leadership team.</p> |
| Audit Wales CHC Follow up BCU-2223-21 | 211 | Governance, accountability and performance. | Reasonable | High | <p>Outstanding</p> <p>Whilst narrative was provided on the governance arrangements, the evidence referred to was not attached.</p> |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|---|-------------------|---|---------------|-------------------------|---|
| | | | | | To close the action, the following needs to be evidenced: <ul style="list-style-type: none"> - Structure chart - ToRs outlining reporting requirements etc. |
| Digital Strategy BCU-2223-22 | 212 | Funding the implementation of the Digital Strategy. | Reasonable | High | Closed The narrative updated by the Director of Digital states there is no funding available to support the Digital Strategy. The action has been closed as the related risks have been reflected on the risk register. |
| Public Health – Smoke free sites BCU-2223-28 | 219 | Policy not up to date. | Reasonable | High | Closed The policy has been updated and is available on BetsiNet. |
| Financial Control – Receipting of goods and year end accruals BCU-2324-02 | 246 | Procurement guidance and training. | Reasonable | High | Outstanding Evidence provided is a link to the procurement training and feedback link. No details / evidence is provided of the numbers of staff who require training, how many have had training or forward training |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|------------------------------------|-------------------|----------------------|---------------|-------------------------|--|
| | | | | | <p>plans. The Financial Control Action Plan was referenced but no further information was included.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Data on training completion / compliance i.e. number of staff who require training / number completed etc - Forward training plans (as referenced) |
| Accounts Receivable BCU-2324-03 | 275 | Cash Deficit. | Reasonable | High | <p>Outstanding</p> <p>Narrative was provided however the only evidence provided was an email confirming a meeting would be taking place.</p> <p>To close the action, the following needs to be evidenced:</p> <ul style="list-style-type: none"> - Updated Standard Operating Procedure |

| Review Title and reference | Audit tracker ref | Recommendation Title | Report rating | Recommendation Priority | Follow-up status and summary |
|----------------------------|-------------------|----------------------|---------------|-------------------------|--|
| | | | Yellow | Red | - Evidence of review of variances by Finance |

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:

| | | |
|--|-------------------------------------|--|
|  | <p>Substantial assurance</p> | <p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected</p> |
|  | <p>Reasonable assurance</p> | <p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.</p> |
|  | <p>Limited assurance</p> | <p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.</p> |
|  | <p>No assurance</p> | <p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations</p> |

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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AUDIT COMMITTEE - AUDIT TRACKER

| ID | Committee | Internal Audit (IA)/ Wales Audit Office | Report Title | Year | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Update provided to 12/01/2024 Audit Committee | Action Owner | Final Approver | Recommendation State | Original implementation date | Revised implementation date | Number of Revisions | Actual Implementation Date | Date Final approved | Recommendation open or closed or pending |
|-----|------------------|---|---|------|-----------------|----------|---|---|---|--|--|---|-----------------------|------------------------------|-----------------------------|---------------------|----------------------------|---------------------|--|
| 119 | Audit Committee | Internal Audit | Integrated Service Boards (ISB) | 2022 | Limited | High | 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. | 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 | All Frameworks have been approved at Board in September 2023. The Acting Board Secretary recognises that the new Operating Model has been implemented since this action was first put forward, therefore the context has now changed and been superseded by that implementation. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | Final Client approved | 30/06/2022 | 30/09/2023 | 4 | | 25/10/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 193 | PFIF | Internal Audit | Charitable Funds | 2022 | Limited | High | 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. | 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 their role as a Board member of the Corporate Trustee. Spotlight on a Fund and Fund Advisor, so they are aware of the responsibilities and actions of those who are charged with overseeing different funds on behalf of the Corporate Trustee. Updates on grants awarded and grant impact. Review of internal and external communications. 1.2 A review of the content and frequency of information provided to Trustees will be tabled at the Charitable Funds Committee for discussion and reviewed at the Trustee meeting. | Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair/Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM & Exec updates and regular communications are included on the Betsinet page. The info for the IMs provided for handbook: included in the 30/03/2023 Trustees meeting and the intro sent to the CEO, for example. BetaNet information regularly updated for Trustee Board to keep abreast of developments, and additional information regarding governance now included on Charitable Funds Committee webpage - additional evidence provided. | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/01/2023 | | 0 | 04/05/2023 | 22/08/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 205 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | High | PADR Compliance and WARRN training | Further progression is needed in order to achieve the overall divisional completion target of 85%. Focus is necessary to increase the uptake of training within areas of the division | Divisional PADR compliance rates to be an Agenda item in all local Operational Delivery meetings, with focus on staff who have never had a PADR (as at 31st January 35 Divisional staff recorded); Never had a PADR Starter (as at 31st January 43 Divisional staff recorded); Out of date 24-months (as at 31st January 35 Divisional staff recorded); PADR completed but not recorded (as at 31st January 4% (n76) noted). To ensure the Division meets the target compliance of 85% by 31/5/2023. Business Support Managers to include a detailed analysis of area PADR compliance data in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss PADR compliance rates during local area Operational Delivery meeting, identify any barriers and support needed to ensure compliance of 85% is met by 31/5/2023 across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include PADR compliance rates, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting (formally DSLT Finance and Performance meeting, Tier 2) to monitor and review progress. The Divisional Key Performance Indicators aligned to PADR to be scrutinised and any additional intervention discussed and agreed for areas under achieving. Reaffirm importance of and recording of PADRs within the MH&LD Staff Briefing. Include monthly PADR compliance rates in the Divisional Improvement Plan KPI data to show trajectory of improvement. WARRN TRAINING. Identify and book alternative accommodation to enable WARRN training sessions to accommodate 25 staff, instead of current 15 staff, to enable an increase in numbers of staff trained each month in order to increase training compliance from 62.5% to 85% by 30/9/2023. Provide monthly WARRN training compliance data, including analysis of individual area/department compliance, to HSE NOK Delivery Group meeting to enable monitoring, review and early identification of any barrier to delivery of meeting compliance target rate of 85% by 30/9/2023. Continue with delivery of twice monthly WARRN training sessions to ensure an additional 200 divisional staff complete WARRN training to meet 85% compliance. Set up a process to ensure new starters in the MH&LD Division are included in the monthly WARRN training sessions. | MH&LD Divisional PADR compliance remains above 85%, with October compliance recorded at 86.79%. MH&LD Divisional PADR compliance is presented at the MH&LD Service, People and Culture meeting, latest PADR report and Agenda embedded below. In addition PADR compliance is included in all local area Performance reports (embedded below) with Exception reports presented in MH&LD Divisional Finance and Performance meetings. | Adrianne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MH&LD | Final Client approved | 30/04/2023 | | 0 | 26/06/2023 | 31/08/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 211 | PFIF | Wales Audit Office | Audit Wales CHC follow-up | 2022 | Reasonable | High | Governance, accountability and performance | The Health Board review the governance and accountability arrangements for CHC which brings together people, quality, performance and financial information. | Continuation of Contracts and Finance reports to PFIF. Continuation of Quality Assurance Framework update to Regional Commissioning Board and Regional Partnership Board. CHC reporting structures (Quality, Finance, and Performance) will be reviewed and there will be a recommendation made to the Executive team regarding a proposed governance and reporting structure for CHC. This will include a proposal that there is Executive Board agreement regarding the Exec lead for CHC, in line with the new Operating model. It will also help to formalise reporting, ensuring a quarterly report goes to a sub-group of the Board. Terms of Reference for CHC/Care Home Quality and Commissioning Group (SMT) will be reviewed. This will strengthen SMT membership in line with recent changes and establishment of IHCS. Further work will be carried out to align the IHC and corporate risk registers. The updated corporate risk register will then be issued for Executive sign-off. The CHC Operations Group TOR will be reviewed to ensure there is a strategic focus, as operational items are included in the Case Management Group remit. | Action complete, and can be closed. Additional evidence provided as latest SMT update. | Jane Trowman, Head of Strategy and Health Planning | Chris Stockport, Executive Director Transformation and Strategic Planning | Final Client approved | 31/03/2023 | 30/09/2023 | 1 | | 28/11/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 246 | PFIF | Internal Audit | Financial Control – Receipting of goods and year-end accruals | 2023 | Reasonable | High | Procurement guidance and training | Ensure all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. Review the evidence provided for Purchase Order 9705645 for £293,787 and ensure it is accounted for in the correct financial year. | In relation to training, we have to date focused on the provision of essential guidance and training on year-end processes for BCU colleagues in order to mitigate the risk of expenditure being accounted for across BCU in the wrong year at the 2022/23 year-end. Acknowledgement of this is welcome. The assessment of longer-training training needs and the delivery of an ongoing programme of training across BCU are addressed in the Financial Control Environment Action Plan. In relation to the specific Purchase Order 9705645 we confirmed that this was not accrued for in the 2022/23 year-end. It will be accounted for as appropriate in 2023/24. | Additional evidence of Oracle Refresher Workshop provided | Andrea Hughes, Interim Director of Finance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2023 | 01/11/2023 | 1 | | 22/08/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 249 | People Committee | Internal Audit | Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 2023 | Limited | High | Remuneration and Terms of Service Committee – Reports for assurance | Management must ensure Committee Members are appropriately involved in determining the information they require for assurance and subsequent reporting/providing advice to the Full Board. As a minimum, any report to be submitted to the RATS Committee in relation to the appointment of an interim must incorporate assurance on compliance on key matters of control in Standing Orders, Standing Financial Instructions and Welsh Government instructions. | R&TS committee Terms of Reference is being updated and will be ratified in May 2023. The R&TS committee will define the required parameters of the reporting structure and make it's recommendations to board. A new reporting template for R&TS and the Executive Management Team will be implemented, to incorporate all JESP/OSM appointments, both interim and substantive, and whether the appointments are compliant with standing orders, SIs and WG instructions. In addition, the report will include details of permanent recruitment timeframes when a post has been filled by an interim. | The REMCOM terms of reference were approved, and have been provided as evidence. The senior interim report that was agreed in September 2023 will be provided to every meeting (bi-monthly) until further notice. | All Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | Final Client approved | 30/09/2023 | | 0 | | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |

| | | | | | | | | | | | | | | | | | | | |
|-----|------|----------------|---|------|------------|------|---|---|---|--|---|--|-----------------------|------------|------------|---|------------|--|--|
| 269 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability | 2023 | Limited | High | Accountability meetings (b) | Review current action tracker to determine whether actions are still relevant. | Action tracker to be reviewed for relevance by end of July 2023. | Accountability meetings now underway. Action to be closed. Monthly Integrated Performance Executive Delivery Group set up chaired by CEO, monthly meetings held every third Wednesday. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 31/07/2023 | 29/02/2024 | 1 | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted | |
| 275 | PFIG | Internal Audit | Accounts Receivable | 2023 | Reasonable | High | Cash Deficit | The Health Board should ensure that any discrepancies between money banked and payments receipts be fully investigated and formally reported to establish reasons and prevent further occurrences. | The discrepancies identified between receipts and bankings have all now been confirmed as being timing differences, which were subsequently banked in all cases. Timing differences arise when cash is taken late in the day and therefore can only practically be banked the following day. Prompt action has been taken to meet with the Catering Manager in Denbigh and Ruthin where the audit findings were discussed and immediate changes to their banking processes have been enacted which will ensure any discrepancies arising from timing differences are explicitly followed through and secure banking confirmed as a matter of routine. Initial meetings have also been held with the Manager and Assistant Manager of YGC Catering, and we are now setting up more robust processes relating to the 'Midnight Till' and where cash is held over before being transferred to General Office. Turnover of cash is reducing due to the fact that card machines are now in the majority of our Community Hospitals. The General Office Manager continues to remind staff of the procedures to follow and actively provides re-fresh training to staff. A planned half-day targeted session with all Community Hospital General Offices is taking place in October, and this will be a further opportunity to reiterate the requirements set out in our procedures and to respond to any practical queries that they may have and to look at best practice. | Further evidence to support closure provided. | Ronnie Bright, General Office Manager | Russell Caldicott, Interim Executive Director of Finance | Final Client approved | 17/08/2023 | | 0 | 17/08/2023 | 22/08/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 277 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Clinical Audit Plan | The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee. | The Clinical Audit Plan for 2023/2024 was prepared and submitted initially to the Strategic Clinical Effectiveness Meeting on 14th February for discussion and agreement. Following this the Clinical Audit Plan was prepared and submitted to Quality, Safety and Experience Committee (QSE) on 7th March, the meeting was then stood down. The paper was then submitted to Quality Delivery Group (QDG) on 17th April, due to QSE not having any further dates to present at that time and due to changes in Board membership all of the Committees were not meeting at that time. It was therefore appropriate Nick Lyons signed it off as Executive Medical Director and Acting Chief Executive Officer at that time. | The Clinical Audit Plan for Tier 1 went to QSE Committee in August and is incorporated into future cycle of business from Strategic Clinical Effectiveness Group to be submitted when relevant. The quarterly reports show the current situation at that time of relevant published Tier 1 reports and where they are in the cycle process and any concerns are escalated to QDG and QSE where relevant. Processes are in place to flag up concerns on monthly basis within local Clinical Effectiveness Group with approach of sorting those concerns and avoiding escalation where possible. Due to local Clinical Effectiveness Groups running differently on each site, from November the Clinical Effectiveness Team sharing a monthly update to each IHC and Divisions sharing current position with regard to Tier 1, Tier 2 and NICE - if any concerns or risks that need addressing, and these will be monitored and if no change escalated then escalated to Strategic CEG. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/07/2023 | | 0 | | 31/08/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 280 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Progress reporting of Tier 1 audits (a) | The Health Board must ensure appropriate meetings within the governance structure take place as required and include clinical audit as an agenda point to allow adequate review and scrutiny of the issues affecting the Tier 1 process. | The quarterly reports that are produced from Clinical Audit Team capture which audits have been published in relevant quarter and includes all BCU identifiable data – plus process and completed actions and outstanding issues. These are followed up by Clinical Audit Facilitator at local CEGs. We have recently set up an Audit/NICE monthly meeting and we would capture any areas of concern that need taking to Strategic CEG to close the loop. A cycle of business (COB) has been developed to ensure relevant papers go to appropriate meetings. | In Clinical Effectiveness Department, we ensure through our processes that we monitor and review any issues affecting the Tier 1 process. These are raised with local Clinical Effectiveness Groups to be aware and discussed how to manage. If failure to address these issues is not met then they will be escalated to Strategic Clinical Effectiveness Group, to discuss and if cannot be addressed would be raised in Chairs Report to Quality Audit Delivery Group for decision making. Clinical Audit Facilitator at local CEGs. Our new process is to share on a monthly basis to all IHCs and Divisions an update of current situation with Tier 1, Tier 2 and NICE Compliance in the process and this is shared with Head of Clinical Effectiveness and Deputy Executive Medical Director. Within our CE team we have set up a monthly Audit/NICE monthly meeting and where we discuss areas of concern that need taking to Strategic CEG to close the loop. A cycle of business has been developed to ensure relevant papers go to appropriate meetings. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 31/03/2024 | | 0 | | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
| 282 | QSE | Internal Audit | Clinical Audit – Tier 1 National Audits | 2023 | Limited | High | Learning from audits (a) | Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process. | Following recent meeting with Internal Auditor the Service assessment form was amended July 2023 to request evidence of discussions and how these are shared as part of the assurance process. Clinical Audit Facilitators will ensure that all details are completed before accepting the form as completed and the update will be included in the relevant quarterly report. | The Clinical Audit Facilitators have developed a Service Assessment of Compliance against Key standards (SAC) form which is sent to the Clinical Audit Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. This information is then captured in the Quarterly reports and Annual report and also shared within local Clinical Effectiveness Groups (CEG). We review our processes regularly to ensure we are capturing as much as we can to share at relevant groups. On monthly basis we share an update with IHCs and Divisions on their current position with Tier 1 audits which shows the current position/progress also noting any concerns that need addressing. If this is not done through the relevant local Clinical Effectiveness Groups, then a paper would be produced to take to Strategic Clinical Effectiveness Group to discuss further. Additional evidence to support closure provided. | Joanne Shillingford, Head of Clinical Effectiveness | Nick Lyons, Executive Medical Director | Final Client approved | 23/07/2023 | | 0 | 16/10/2023 | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted | |
| 293 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. | 2.1a Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated. | Good practice examples shared pan BCUIHB alongside ongoing peer review process. In addition, as of January/February 2024 many staff will be required to update their Mandatory Training (which will be via the updated modules). IHC Leads will provide ongoing assurance of local Mandatory Training levels via the monthly Falls Steering Group. | Chris Lyles, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | 31/08/2023 | | 0 | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted | |
| 297 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1c Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms. | 2.1c Training resources outlined 2.1a will include the re-enforcement of when the FBHMA requires review and updating in line with national standard. The B6 Clinical MH Advisors now lead the patient risk assessment beside learning programme (for falls and patient handling risk assessments) for the H&S team. | New Welsh Nursing Care Record upgrade flags on transfer to ward to complete Risk Assessments. A reminder to complete is also included in the training. The monitoring of compliance as stated is continually monitored and reviewed via existing ward metrics and now also with the peer reviews. | Chris Lyles, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | 30/10/2023 | | 0 | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted | |

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| 302 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. | Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. - Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; - the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments. | Monthly report now to be submitted to ward accreditation lead nurse to inform on falls training for agency workers. Additional evidence to support closure provided. | Clair Tipton, Head of Digital Workforce and Resourcing | Angela Wood, Executive Director of Nursing and Midwifery | Final Client approved | | | 0 | | Approved for closure at 12/01/2024 AC - Pending closure approval by IA - IA recommendations received - additional evidence submitted |
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**AUDIT COMMITTEE
AUDIT TRACKER**

| ID | Committee | Internal Audit (Iu)/ Wales Audit Office (AWO) | Report Title | Year | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Update provided to 12/01/2024 Audit Committee | Update for 15/03/2024 Audit Committee | Action Owner | Final Approver | Original implementation date | Revised implementation date | Number of Revisions |
|-----|-----------------|---|--|------|-----------------|----------|--|---|---|---|---|--|--|------------------------------|-----------------------------|---------------------|
| 57 | QSE | Internal Audit | Quality Improvement Strategy | 2020 | Limited | High | Reporting progress of Quality Improvement Strategy (QIS) | For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan. | The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones, that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE. | This action remains on track and was subject to discussion at the Quality Governance Round Table Meeting with Welsh Government in November 2023, and forms part of the 2023/24 business plan for the Quality Governance Department. | The new CEO has confirmed the intention is to develop an integrated quality framework aligned to the Quality Management System, rather than a separate strategy. The QMS is a new statutory requirement of the Duty of Quality introduced in 2023 and is a key priority for the Special Measures Programme. As such this action is closed and the work will be taken forward as part of Special Measures and the Duty of Quality. An Executive Workshop has been held, as has a Senior Leadership Team Workshop, and a Board Workshop is planned for Q4. Therefore, this action from 2020 is fully superseded by new legislation in 2023 and the new direction of the Health Board. | Matthew Joyce, Assistant Director of Patient Safety and Experience | Angela Wood, Executive Director of Nursing and Midwifery | 01/08/2020 | 31/03/2024 | 11 |
| 73 | PFIG | Internal Audit | Performance measure reporting to the Board – Accuracy of information | 2021 | Reasonable | Medium | Standard Operating Procedure | Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Ensure Risk Stratification controls and procedures are formally documented. | The RTT 26 Week Pathways Standard Operating Procedure is out for consultation and awaiting response from stakeholders. Previous feedback comments are being fed into the document and once all responses are reviewed the Standing Operating Procedure will follow the official sign off route via the Planned Care Board and Planned Care Transformation Group. The Head of Ambulatory Care post once filled will be responsible for owning and implementing the Standing Operating Procedure as best practice across BCUHB. | Update required | The RTT 26 week SOP has been created and ratified, the education and training of this SOP has been conducted August 2021. However, since the creation of the document West have migrated onto WPAS from IPM and an Access Policy has been created that will supersede this document. The Access Policy has concluded final consultation and is being ratified. | Andrew Oxyb, OPD Programme Support Manager | Adele Gittos, Interim Executive Director of Operations | 02/08/2021 | 30/04/2024 | 5 |
| 114 | Audit Committee | Internal Audit | Standards of Business Conduct: Declarations | 2022 | Limited | High | 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. | 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 to be 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 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. | MS Declare is now live for both Declaration of Interests and Gifts and Hospitality. All members of staff have been issued individual emails and log in details of how to make a declaration. The Declarations sharepoint site has been updated. Staff are reminded regularly to submit and we have received a targetted email list of Band 8a and above to enable a personalised email from the Office of the Board Secretary office to be sent to these individuals. The action to remain open until the Declare System is fully embedded. | The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for Standards of Business Conduct will highlight future areas of focus. This is still in its first year of infancy and we appreciate that there will be future improvements to be made but original action now closed. Copy of Audit Committee agenda bundle provided as evidence to support closure. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/06/2022 | 31/01/2024 | 3 |
| 115 | Audit Committee | Internal Audit | Standards of Business Conduct: Declarations | 2022 | Limited | Medium | Declarations of Interest Compliance | 1.1 The Standards of Business Conduct policy is reviewed and updated where required, including further information: • Those roles below band 8c that require a declaration of interest • Responsibilities of Governance Leads to ensure compliance within their areas Medium Standards of Business Conduct Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 12 • Monitoring and reporting arrangements | Agreed, the policy has been updated with a view to incorporating best practice identified from the All-Wales Standards of business conduct Policy as well as the requirement for all staff to submit a declaration of interest annually. | The policy has been updated and is due for review in 2025. However, the policy will be reviewed again sooner than 2025 due to an audit this month, and the policy remains ambiguous. There is further work to be undertaken with Governance Leads to ensure they are aware of how to review Declaration of Interest. All staff have been targeted to complete a Declaration of Interest and Gift and Hospitality, however, further work will be undertaken, and Band 8a and above will also be targeted by an email from the Office of the Board Secretary. The action to remain open until the Declare System is fully embedded. | The action that was prescribed in 2022 has been completed and the policy is due to be reviewed in 2025. As such the original action can be closed as we recognise that the 2024 internal audit for standards of business conduct may require further action. Copy of policy provided as evidence for closure. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/06/2022 | 31/01/2024 | 1 |
| 116 | Audit Committee | Internal Audit | Standards of Business Conduct: Declarations | 2022 | Limited | High | 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. | 2.1 Agreed, however a new system is being put in place with effect from April 2022, which will be managed directly by the Office of the Board Secretary, and monthly updates from ESR will be incorporated onto the MES Declare system to ensure its accuracy and completeness. 2.2 Exception reports will be generated on a monthly basis on the new system, and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late. | The next report will be provided to Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded. | The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. A meeting is to take place to ensure that mismatched information between Declare and ESR can be solved. However, the original action has been closed. Copy of Audit Committee agenda bundle provided as evidence to support closure. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/06/2022 | 31/01/2024 | 3 |
| 117 | Audit Committee | Internal Audit | Standards of Business Conduct: Declarations | 2022 | Limited | Medium | Gifts and Hospitality requirements | 4.1 The guidance regarding the process of accepting/declaring gifts as well as Hospitality should be circulated/highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors/Assistant Directors of their role in approving hospitality prior to acceptance. | Agreed, a communications plan will be put in place to publicise the importance of disclosure of gifts and hospitality as part of the process of raising awareness on the requirements of the Standards of business Conduct Policy. (Consideration is also being given in relation to making the process of accepting / declaring gifts as well as Hospitality and the submission of an annual declaration of interests (even a Zero return), to be recorded as part of employees' Annual appraisal process. The level of compliance can then be monitored from the systems where the Annual Assessment or PADR is recorded. The feasibility of this approach is being considered.) | This process was implemented when MES Declare went live. A report will be received at the Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded. | The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. Copy of Audit Committee agenda bundle provided as evidence to support closure. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/06/2022 | 31/01/2024 | 2 |
| 118 | Audit Committee | Internal Audit | Standards of Business Conduct: Declarations | 2022 | Limited | High | 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. | 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 to evidence compliance. | The system is now in place and a number of reports have been drawn down. The Board Secretary and Head of Corporate Affairs will review what data is required to be presented at the Meeting in January 2024. The action to remain open until the Declare System is fully embedded. | The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. Copy of Audit Committee agenda bundle provided as evidence to support closure. | Phillipa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 31/05/2022 | 31/01/2024 | 3 |

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| 123 | PFIG | Internal Audit | Procurement and Tendering | 2021 | Reasonable | Medium | E waiver system | Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met. | 3.1 We will investigate the possibility of updating the eWaiver system (as part of the 365 redesign) to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended. | Go live has been put back until November to allow time to incorporate some key governance updates in the waiver process. The eWaiver system has been reviewed and updated with the intention of using 365 functionality. Additional enhancements have been made in line with SFI and SORD (approved by Board 30/11/2023). Soft launch scheduled imminently (December 2023). | The Finance Department have been re-developing the waiver system and following a period of user testing and a soft launch in December 2023, the system went live in February 24. Key areas of improvement are system compliance with delegated limits contained within the Scheme of Reservation and Delegation (SORD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary; and improved reporting. | Denise Roberts, Head of Capital, Tax and Business Support | Russell Caldicott, Interim Executive Director of Finance | 31/03/2022 | 31/12/2023 | 9 |
| 146 | PFIG | Internal Audit | Women's Services Division – Sustainability of services | 2021 | Reasonable | Medium | Escalation of issues | Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised. | SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and presented to the Health Board's, Chief Executive Officer on 22/10/2021. Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board's Chief Executive Officer. For the attention of Cheshire CCG's Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences to BCUIHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation Trust. Update on actions taken by the Women's Division, in respect of the ongoing quality assurance concerns in the Maternity Service provided at the Countess of Chester, presented at the Women's Executive Accountability meeting on 5/11/21 and at Corporate P50 on 9/11/21. Quality and Safety Audits and Assurances required during a pandemic and when formal contract management reporting resumes, to be formally and agreed with the Countess of Chester Provider Team on 24/11/21. | Update required | A formal request via the BCUIHB Contracting Team has been submitted to request an update from the Countess in relation to: COC follow up finding and Report in relation to Maternity - It has been confirmed that the report is not available as they are still within the inspection phase. - Clinical Outcome measures and KPI Performance now reported Quarterly to the HB via the Contracting Team. - COC - Maternity Improvement Plan and Assurance Outstanding (9-2-24). - Updates provided to QEDG on a quarterly basis | Fiona Giraud, Director of Midwifery and Womens Services | Adele Gittoes, Interim Executive Director of Operations | 31/12/2021 | 31/03/2024 | 8 |
| 147 | PFIG | Internal Audit | Women's Services Division – Sustainability of services | 2021 | Reasonable | High | 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. | NHSE 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 contracting management and reporting requirement, these will however be re-established once that guidance changes. Despite the guidance BCUIHB 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 BCUIHB 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 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. BCUIHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUIHB whilst working outside of normal contracting arrangements, during a pandemic. | Update required | - Clinical Outcome measures and KPI Performance now reported Quarterly to the HB via the Contracting Team. - COC - Maternity Improvement Plan and Assurance Outstanding (9-2-24). - Updates provided to QEDG on a quarterly basis | Fiona Giraud, Director of Midwifery and Womens Services | Adele Gittoes, Interim Executive Director of Operations | 31/12/2021 | 31/03/2024 | 2 |
| 148 | People Committee | Internal Audit | Employment of Medical Locum Doctors | 2022 | Reasonable | Medium | Justification Notes | All requests for recruitment of locum medical staff should be completed to a good level and include all necessary information and justification notes, which will facilitate an effective audit trail. | Clear guidance on minimum information required to be developed in liaison with Finance and Associate Medical Director Professional Standards (Office of the Medical Director 'OMD'). Quarterly compliance audit will be undertaken by WOD/Fin/OMD and included in Contract management information | Due to the changing financial position of the Health Board, the response to this action has been amended as the prior solution was not suitable. In October 2023, a new Rate Approvals group was put in place where services are required to submit detailed justification for high cost locum bookings. Linked to this, a new Temporary Medical Workforce Policy has been developed. The new policy is planned to be ratified in Q4 2023/24. | M&D Medical Locum Staff governance infrastructure implemented and is operating effectively. The new Temporary Medical Workforce Policy has been written, developed and is currently undergoing consultation and engagement activities via the various HB committee structures and is still on track to be fully ratified in Q4 2023/24. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 30/06/2022 | 29/02/2024 | 6 |
| 149 | People Committee | Internal Audit | Employment of Medical Locum Doctors | 2022 | Reasonable | High | 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. | Tripartite Contract Management meetings to be arranged on a monthly basis. Tripartite Senior Contract Management meetings to be held quarterly. | The new BI dashboard is under development and due to be launched by January 2024. | This has been delayed due to staff shortages and sickness across the team and the ability to get the dashboard signed off by senior managers in workforce. The industrial action by junior doctors has also delayed getting final sign off from senior medical leads. Final sign off and launch will be completed by end of February 24. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 30/06/2022 | 29/02/2024 | 4 |
| 150 | People Committee | Internal Audit | Roster management | 2022 | Limited | Medium | Policies and Procedures | Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. Draft SOP needs to be approved and activated. | Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated with safe staffing in conjunction with Corporate Nursing Team. Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period. | The policy renewal took place but ongoing monitoring has shown that further work, led by the nurse optimisation team, is needed in relation to compliance with managing breaks. This is linked to the programme of work to move all nurses onto the e-Roster system to help applying a consistent approach to unpaid breaks across the IHCs. | Further work is ongoing with the Nursing Teams to ensure full compliance is in place to support compliance with the SOP. Work is also underway to hand over the compliance monitoring to the IHC Nursing and People Service teams as part of embedding the oversight and ownership of the process into business as usual practice. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 31/07/2022 | 29/02/2024 | 2 |
| 151 | People Committee | Internal Audit | Roster management | 2022 | Limited | High | Submission of timesheets by agencies | Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements. | Formal letter to be issued to all agencies from Executive Director of Workforce and 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 | It has been identified that further work with nursing is needed to improve compliance with the policy and locking of shifts in a timely manner. | Further training has been provided on roster management to incorporate lock down of shifts and completion of timesheets in a timely manner across identified nursing teams. KPIs are being monitored and will be reported as part of ongoing compliance metrics to ensure shifts are locked down within the required | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 30/06/2022 | 29/02/2024 | 2 |
| 152 | People Committee | Internal Audit | Roster management | 2022 | Limited | High | 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 declaration included on the system where they are confirming the details entered are correct. 3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets/exception sheets before they are locked for payment. 3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments. 3.5 The Temporary Staffing team should regularly check a sample of shifts on the system against paper timesheets retained by agencies. | (as per 1.2) Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care. Revised SOP approved by People and Culture Executive Delivery Group and implemented | The actions relating to this response were completed, however, it has been identified that further improvements are needed to ensure roster users are following the new SOP. | The SOP has been further embedded and a rolling audit cycle is now being put in place to ensure all areas remain fully compliant. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 31/08/2022 | 29/02/2024 | 2 |

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| 154 | People Committee | Internal Audit | Establishment control – Leaver management | 2022 | Limited | High | 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. | The Workforce Performance and Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation. The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager, however, ESR will serve as the prompt and workforce teams can monitor and escalate if compliance is not adhered to. The specific actions will be: 1. To advise the NWSSP Team, wider stakeholders i.e.; Finance, HR that with effect from the 1 February 2022 the team will be requesting all future agenda for change staff terminations to be completed via ESR Self Service. 2. Issue a BCU wide communication to advise that with effect from the 1 February 2022 all agenda for change staff terminations must be completed via the ESR Self Service system. 3. Initiate a mass upload from IBM to add against each staff member a minimum property list of ID Badge and IT equipment/Network access credentials. 4. ESR function actioned so that a notification is sent of individual staff terminations to specified colleagues/groups. This will be piloted with IT and Security to ensure the notifications are received with the relevant information i.e. employee leaving date with a view to stop the monthly leavers report issued to IT as terminations will be notified in real-time. | No 4. - There remain technical issues to be resolved with the existing changes forms and self service function which has impacted the completion of this action. Whilst the ESR Self Service system sends the notifications to IT colleagues, it does not provide the details required. IT colleagues need to understand if the leaver requires their NADEx account to be terminated and leaving BCU is not always an indicator to terminate the NADEx as they may be moving to another NHS organisation in Wales or retiring and returning to BCU, the recent Pension changes will help address the retire and return staff members. A new all Wales changes form (Staff Movement Advice) is due for release in 2024 and will be expected to resolve this action. | This is still an outstanding issue and sits outside of BCUs direct control as it is a NWSSP initiative. The current expected delivery date we have been advised of is 31/04/24. As far as the team are aware this is still on track and regular updates are requested from the shared services team responsible for implementing this across Wales. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 31/01/2022 | 31/04/2024 | 3 |
| 155 | People Committee | Internal Audit | Establishment control – Leaver management | 2022 | Limited | Medium | Leaver data provided to areas/departments | Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas/departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce and OD. | There are four interventions to assist with supporting the wider leaver management reporting process: 1. The monthly production of the ESR Leavers Report compared to the ESR Change Event Log by Division. This will highlight the number of leavers terminated in ESR after the leaving date, this will be grouped by month for high level numbers. 2. The monthly review of Establishment Control requests which highlight the EC request is relating to a team member being replaced. The check to be completed will be comparing the team member noted on the EC request with the ESR Leavers Report and follow up action with the EC requestor regarding why the team member hasn't moved departments or been terminated. 3. Both interventions above will ensure that non-compliance reporting is more targeted. The enhanced reports will be included in the monthly exception reports and shared with Heads of HR and with relevant Senior Leadership Teams. Each quarter the report will be aggregated and will include details of the supervisors who are repeat offenders. 4. Where there is a lack of compliance training and support will be put in place in conjunction with IT and IG to ensure managers are fully equipped to carry out the actions required. | 1 - Complete 2 - Complete 3 - For re-review to ensure the data is being reviewed from within the Teams Channel and or included in Workforce BI Dashboard 4 - For re-review. | 3 - The details being shared with managers has been reviewed and is amended to provide more detailed information. 4 - This is under an ongoing discussion with IT and IG currently and a solution should be in place by agreed revised implementation date. | Nick Graham, Workforce Optimisation Advisor | Jason Brannan, Deputy Director of People | 31/01/2022 | 31/03/2024 | 1 |
| 158 | PFIG | Internal Audit | On-Call arrangements | 2022 | Limited | High | 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, 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. | 1.1a The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead. 1.1b Proposals will be presented to the Executive Team, for approval. | Update required | Review re-commenced in light of WOD elements raised formally, T&F group to be convened with Silvers/BOCs to develop governance/policy and training with a clear plan by April 2024 for implementation in line with all Wales on call process. | Geraint Farr, Associate Director of Unscheduled and Emergency Care | Adele Gittoes, Interim Executive Director of Operations | 12/10/2022 | 01/06/2024 | 3 |
| 159 | PFIG | Internal Audit | On-Call arrangements | 2022 | Limited | High | Rota guidance/sustainability | The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it. | 2.1 On-call document, covering the recommendations above will be issued to all staff. | Update required | A request has gone through the all Wales EPRR teams for copies of any local on-call policies or check the appetite for an all Wales policy that supports all levels of staff, which will manage governance, payment, rest periods. Responses have been requested by month end in light of the ongoing delays. | Geraint Farr, Associate Director of Unscheduled and Emergency Care | Adele Gittoes, Interim Executive Director of Operations | 01/07/2022 | 01/06/2024 | 1 |
| 160 | PFIG | Internal Audit | On-Call arrangements | 2022 | Limited | High | 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. | 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 and OD, and Deputy CEO. | Update required | National support has been requested in light of duration for internal review / updates request has gone through EPRR forum across Wales. | Geraint Farr, Associate Director of Unscheduled and Emergency Care | Adele Gittoes, Interim Executive Director of Operations | 11/07/2022 | 01/06/2024 | 1 |
| 161 | PFIG | Internal Audit | On-Call arrangements | 2022 | Limited | High | 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 expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with. | 4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey. 4.1b Manual to be developed with key 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. | Update required | National support has been requested in light of duration for internal review / updates request has gone through EPRR forum across Wales. | Geraint Farr, Associate Director of Unscheduled and Emergency Care | Adele Gittoes, Interim Executive Director of Operations | 12/12/2022 | 01/06/2024 | 1 |
| 169 | QSE | Internal Audit | Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website | 2022 | Limited | High | Policy and Management of Website Information | 1.1 Health Board to establish formal policy to support the management of the Health Board website (and other digital) content. 1.2 Management review website user administrator access privileges and establish controls to ensure amendments or additions to the Health Board website are subject to review and scrutiny prior to publishing. 1.3 Management to establish controls or monitoring arrangements to ensure that changes published on the English web pages are also actioned on the Welsh pages. | 1.1 Establish a formal policy and guidance to support the management of BCU digital channels, including the website. 1.2 Review current administration access to the BCU website and issue revised guidance and training where required. 1.2 Commission support to conduct a review of the website to identify and rectify any discrepancies with existing Welsh/English content. This will be a six-month project to provide a robust review of the website. This will be funded by the Corporate Communications Team. 1.2 Recruit a dedicated translator for the Corporate Communications Team to manage all translation requests for the website ensure content is published simultaneously link with Welsh Language team to maintain translation standards. This will ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. The funding for the first 12 months of the post has been agreed, during which time a business case will be made for the post to be permanently established within the team. 1.2 All devolved editors will be contacted and reminded about the translation and publication requirements for the website and offered refresher training sessions. 1.3 Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website and resolve issues with delayed translation requests. 1.3 Establish a programme of audits to monitor the website on a monthly basis. | The draft report has been received back from the Auditors to confirm all actions have been completed. However, work is ongoing in order to undertake random checks on web pages to ensure continued compliance with protocol. | In terms of the website audit, the final report has now been received and shared confirming all actions were completed. The ongoing monitoring is part of our established control measures so if this is the reason this recommendation cannot be closed then it may remain permanently open as that monitoring will continue indefinitely. | Andrew Rogers, Head of Corporate Communications | Teresa Owen, Health Board Lead for MHL and Welsh Language | 31/03/2023 | 31/01/2024 | 4 |

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| 172 | PFIG | Internal Audit | Effective Governance: YWM | 2022 | Limited | High | Finance | Management to identify and progress savings schemes as a matter of urgency. Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model. | A revised control total has been set for the EHC. E IHC is an exemplar area for CHC savings. The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022. | Update required | Monthly meetings are held with teams to identify, monitor and share learning around the savings targets. This has allowed us to progress CRES targets. There is a monthly finance and performance meeting for all areas to report into and new for 2024 is the deep dives into the areas. The chief finance officers are an integral part of the IHC meetings and input to all decision making. The last meeting held on Wed 28th Feb. All meetings take place on the last Wednesday of every month, previous meetings 29th Nov, 25th Oct, 27th Sept on a rolling monthly occurrence. CRES meetings – monthly CRES meetings take place (not minuted) with all directorates to meet with the EAST IHC Directors and Finance to update on their financial position so far and to discuss savings plans and how they can help to deliver a balanced year end outturn. There was also a deep dive done on finance and EHC presented at PFIG on 22nd February 2024. | Michelle Greene, Integrated Health Community Director (East) | Adele Gittoes, Interim Executive Director of Operations | 31/03/2023 | 05/02/2024 | 1 |
| 173 | PFIG | Internal Audit | Effective Governance: YWM | 2022 | Limited | High | 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 be 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. | The East Clinical Effectiveness Group is established in the new governance plan and includes both the YWM and Community Services Medical Directors, so is already happening. The Director of Nursing for East chairs this and the T3 audits are shared in this forum, as are the results and recommendations. The imminent commencement of a newly appointed EHC Medical Director will enable, as part of the wider team, a robust, structured approach to developing and delivering the action plans. | Update required | The East IHC Clinical Effectiveness Group (ECEG) is now established and chaired by the secondary Care Medical Director. It covers the full breadth of the EHC. There is input from the clinical audit team. AMA7 is established as the tracking system for the Tier 1, national and corporate audits. It is not yet being used for the Tier 3 audits but we will work on this in 2024. | Emma Jane Hosking, Hospital Site Medical Director/ Consultant Anaesthetist | Adele Gittoes, Interim Executive Director of Operations | 23/11/2022 | 28/02/2025 | 2 |
| 175 | PFIG | Internal Audit | Effective Governance: YWM | 2022 | Limited | High | Risk Management | 5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions/dates are included. 5.1b Management to review consistency of reporting in accordance with the revised Operating Model/governance structure. | EHC Risk Management Group have met twice to date. All level 1 and 2 risk discussed and divisions tasked to review all risks within own areas. Some risks sit within East as corporate risks and some sit within operational estates. Ongoing review of risks, Level 3 – Quarterly, Level 2 – Bi Monthly Level 1 – Monthly. Risks for Acute Site, Childrens, HMP Berwyn, Primary Care, Facilities and Community Services have been amalgamated into an EHC Integrated Risk Meeting, risk register currently under review. | Update required | There is now a Wom site Risk meeting, this reports to East IHC Risk and Governance Meeting as per the requirements of RMO1, this has been in place since September TOR attached. The monthly meetings are minuted, have an up to date TOR (we are waiting the new revised RMO1 so that we can update the TOR). Copy of agenda and minutes provided as evidence for closure. | Ian Donnelly, Acute Care Director | Adele Gittoes, Interim Executive Director of Operations | 31/03/2023 | | 0 |
| 178 | PFIG | Internal Audit | Effective Governance: YG | 2022 | Limited | High | 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. | A full list of Tier 3 audits will be Shared via the next Quality Safety and Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focused 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 | Update required | A tier 3 audit programme has been developed for 2023-24. This was shared at the IHC's Quality Local Delivery Group on 31st October 2023. It is available on the Intranet based on those projects registered via the Clinical effectiveness portal. A weekly update on the delivery of tier 2 audits is also available on the intranet. The audit and effectiveness monthly update that was shared at the Quality LDG on 28 th November 2023 is attached. A monthly report is now provided in this format to track progress and as a means of escalation. An update on Tier 1 audit compliance (as at 15 th January 2024) is attached, showing the west as the best performing IHC in relation to compliance (65% responded to in time, 22% response awaited but still in time, 9% no response and overdue.) Clinical teams are now better engaged with the process; for example the Surgical Directorate are about to commence a Consent to Treatment audit, and this will be reported through the Quality LDG. Downloads from the intranet detailing the current position can be shared for further assurance if required. Additional evidence relating to the audit provided as evidence for closure. | Jamw Hughes-Evans, Interim Area Nurse Director West | Adele Gittoes, Interim Executive Director of Operations | 31/12/2022 | 31/03/2023 | 2 |
| 183 | Audit Committee | Internal Audit | Board and committee reporting | 2022 | Limited | High | 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. | 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. | The Corporate Calendar is now in place and work is ongoing to produce the calendar for 2024-2025. The SOP is implemented. Although the original (2022) recommendations have been met, this will be monitored and should stay open until the remaining Committees are scheduled to give additional assurance to the Audit Committee. | The Corporate Calendar has now been finalised after agreement with the Chair of the Health Board and has now been published along with the Governance routes and dates. On the second part of the calendar there are detailed timelines on all Committees. The Corporate Calendars were published on BCUIHB website on 09/02/2024, and a copy provided as evidence for closure. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 31/12/2022 | 31/03/2024 | 2 |
| 184 | Audit Committee | Internal Audit | Board and committee reporting | 2022 | Limited | High | Submitted papers meet the Board / Committee requirements. | 2.1 Management to ensure that papers and reports submitted to the BCU Board, Committees, or Advisory Groups are of the expected standard, meet the requirements of the Board / Committee and have been reviewed and quality checked prior to being submitted. Submissions to comply with Board / Committee Paper Assurance and Publication SOP. 2.2 Health Board to consider undertaking a root cause analysis of Board and Committee paper and report quality to determine whether there are underlying factors impacting the frequency of issues raised and determine appropriate solutions. | 2.1 We will put in place three line of defence processes in assurance reporting, which will enable more focus on the requirements of the Board and its Committees, as well as the evidence required at an executive level to enable robust reports to be produced. This will also be incorporated within the Board and Committee effectiveness review and incorporated within the overall action plan, which be aligned to the Board development programme. 2.2 Accepted, root cause analysis to be undertaken as a result of the Board and Committee effectiveness review. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. A SOP is now in place and will be monitored with regards to compliance and standards. The Office of the Board Secretary will develop a new report format and roll out training with regards to report writing. It is worth noting that the original action was completed, however the Acting Board Secretary wants to further improve report writing standards. | Further work will be done on this when new Director of Corporate Governance comes into post | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/03/2023 | 29/02/2024 | 1 |

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| 185 | Audit Committee | Internal Audit | Board and committee reporting | 2022 | Limited | High | Reporting Breaches. | Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee. | 3.1 All staff will be reminded of the requirement to complete the breach log in relevant cases. Internal Audit observation: We do not believe the management action mitigates the risk of inaccurate reporting to Audit Committee. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The Audit Committee received a paper on Breaches at its November 2023 meeting, this will continuously be monitored and reporting diligently monitored. | Close and reflect the breaches in context of special measures information on Health Board. Email from WG on Breaches and Audit Committee reports highlighting any breaches in November and January. Additional evidence from WG and Audit Wales provided to support closure | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 31/12/2022 | 31/12/2023 | 1 |
| 186 | Audit Committee | Internal Audit | Board and committee reporting | 2022 | Limited | High | Cycles of Business and Terms of Reference. | 4.1 Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed and approved by relevant committees to ensure continued relevance. Approval should be recorded in relevant meeting minutes. 4.2 Management to consider publishing Board/Committee Terms of Reference and/or Cycles of Business on the Health Board website to promote public engagement and reintroduce the publishing of meeting minutes to improve accessibility. | 4.1 Agreed. The ToR approved by Board in the September 2021 governance review are in the process of being reviewed and proposed to the committees and their approval will naturally be minuted. Committee Terms of reference will also be reviewed as part of the Board and Committee effectiveness review. 4.2 Agreed, these will be published on the website. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Whilst there is more work to do this year, the original action has been completed. | A new Committee structure is in place. The actions have been taken forward. New ToR and Calendar of Business have been approved and will be reviewed and received at each meeting. Additional evidence to support closure is the link to the Corporate Governance report where Committee structure was signed off in September 2023 and in Jan 2024, when ToR were agreed. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/03/2023 | 31/12/2023 | 1 |
| 187 | Audit Committee | Internal Audit | Chairs action | 2022 | Reasonable | High | 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 Ms and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted. | 1.1 The template will be amended as suggested to include the five additional fields. 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 | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. | A Chairs Action protocol was put in place in 2022 and has recently been audited. It is now common practice for us not to routinely use Chair's Actions. There is evidence to show a record of Chairs actions in the Corporate Governance section of each Board report. Copy of Board agenda bundle provided as evidence to support closure. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 31/01/2023 | 29/02/2024 | 1 |
| 188 | Audit Committee | Internal Audit | Chairs action | 2022 | Reasonable | Medium | Standard Operating Procedure | The SOP should be updated to reflect the detail of the process in place and consideration given to which IMs should be included in the approval of the request, where possible using their area of expertise. | The SOP will be updated to ensure alignment with the current practice for Chairs Actions, including the criteria applied for independent member selection, taking into account expertise, and appropriate committee remit | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. | There is a SOP for Chairs Actions. It is now common practice for us not to routinely use Chair's Actions. All new TOR agreed at Board explain process and also the Board report has a section reporting Chairs Actions. Copy of Board agenda bundle provided as evidence to support closure. | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 30/11/2022 | 29/02/2024 | 1 |
| 190 | Audit Committee | Internal Audit | Chairs action | 2022 | Reasonable | Medium | Lessons learned | 4.1 There should be a periodic review of Chair's actions to determine the reason for the action and to establish if any changes need to be made to current processes/approval routes. 4.2 The Health Board should liaise with Board Secretaries/Office of Board Secretaries from HB3 and HB4, which may highlight areas where lessons can be learned to aid in reducing the number of actions. | 4.1 The Board Secretary and Head of Corporate Affairs to review on a Yearly basis the Chair's Actions brought throughout the year. 4.2 Discuss at the national Board Secretaries forum what other organisations are doing and understand if there is the appetite for a once for all Wales approach to the Chair's Action Process. | The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Data set for March review in Office of the Board Secretary calendar. | There has been a dramatic reduction of Chairs Actions but the formal review of it will take place in March 2024 | Philippa Peake-Jones, Head of Corporate Office | Phil Meakin, Interim Board Secretary | 31/01/2023 | 29/02/2024 | 1 |
| 194 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | High | Charitable Funds Committee | 2.1 Review Membership of the Charitable Funds Committee in light of Executive changes, including the quorum required for meetings and update Terms of Reference to reflect any revisions. We suggest a minimum 2 Executives and 2 Independent Members, recognising the wider pool of IM and Executives who are Board of Trustee Members. 2.2 Review responsibilities and objectives of Committee and consider the regular information provided including more qualitative data on the operation of the Charity, updating the Terms of Reference to reflect any revisions. 2.3 Undertake a review of the effectiveness of the Charitable Funds Committee, in line with the requirements of the Terms of Reference (2.1) of the Committee, including requirements of the Charity Commission. | 2.1 New Terms of Reference to be approved by the BCUHB Chairman, the Chair of the Charitable Funds Committee and the Executive Team and submitted for approval by the Charitable Funds Committee and ratified by the Trustee Board. 31/01/23 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to all Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate. 31/01/23 Interim Board Secretary. 2.3 Undertake an effectiveness review of the Committee via survey/interview of all Committee members and non-member regular attendees, and commit to a plan for reporting this and scheduling it in on an annual basis. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item. | The draft CFC ToR is being presented for approval at the CFC 01/24 for ratification at the Trustees AGM 01/24. | 2.1 New Terms of Reference to be approved by 31/03/24 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate by 31/01/24 Interim Board Secretary COMPLETED. 2.3 Undertake an effectiveness review of the Committee in line with BCUHB process ONGOING. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item COMPLETED | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | 31/01/2023 | 31/03/2024 | 2 |
| 195 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | High | Strategy | The Charity Strategy should be presented to Board of Trustees for review and approval. | Charity Strategy to be submitted for approval to the December 2022 Charitable Funds Committee and presented for ratification at the January 2023 Trustees meeting. | The Charity Strategy was approved by the CFC on 03/10/23. The strategy will be ratified at the Trustees AGM 01/24. | The Charity strategy is due to be considered by the Executive Team on 28/02/24 and then submitted for approval by the Charitable Funds Committee on 29/02/24. | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | 31/01/2023 | 31/03/2024 | 2 |
| 196 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | Medium | Policies and Procedures | 4.1 Policies and procedures are reviewed to ensure any changes are reflected. Feedback from the Fund Advisor questionnaire should be incorporated when reviewing the procedures. 4.2 Training for Fund Advisors is reviewed and recommences as soon as possible. | 4.1 Financial Procedures to be reviewed and submitted to the Charitable Funds Committee in March 2023 for approval. Engagement and Communications Procedures to also be drawn up for approval by the Charitable Funds Committee in March 2023. 4.2 New Fund Advisor training package and communications plan to be in place and resourced by April 2023. | The draft Charity Procedures are being presented for approval at the CFC 01/24. New Fund Advisor and Service / Area Charitable Funding Advisory Groups information and training to be introduced from 03/24. | Revised Charity Procedures are being presented for approval at the CFC on 19/03/24. New Fund Advisor and Service / Area Charitable Funding Advisory Groups information and training to be introduced | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | 30/04/2023 | 31/07/2024 | 2 |

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| 198 | PFIG | Internal Audit | Charitable Funds | 2022 | Limited | Medium | Expenditure | A process should be put in place to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity. | A dedicated Grants Manager will be in post by March to ensure a more robust process can be put in place to track funding requests and monitor, evaluate and report funding outcomes and outputs for all charitable activity | The Grants and Data Manager responsible for implementing the actions relating to this recommendation is currently off work. Due to the subsequent reduced capacity in the Charitable Funds and Charitable Partnerships Support team, the actions have not been completed in the anticipated timescale. The revised timeline to improve the process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is as follows: Complete: introduce new application summary template to highlight clear outcomes and outputs for all funding requests, which can be monitored and evaluated; Q3 2023/24 introduce new online application system for all funding requests and update guidance for all charitable funding applicants; Q4 2023/24 introduce a more sophisticated online system to monitor and record updates and evaluations from applicants to be included in Charitable Funds Committee reports and charity communications (subject to the approval of new systems Enthuse charity marketing platform, Donorfy CRM, and ProGrant / other grant management system by IT & IG). The process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is included for noting in the January Charitable Funds Committee (CFC) papers and Grant Management is now a standing item within the Team Update paper submitted to | The Grants and Data Manager responsible for implementing the actions relating to this recommendation has resigned from this role and the duties undertaken by this staff member have been reallocated to team members on an interim basis. Due to the subsequent reduced capacity in the Charitable Funds and Charitable Partnerships Support team, the actions have not been completed in the anticipated timescale. The revised timeline to improve the process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is as follows: Q4 2023/24: introduce new application summary template to highlight clear outcomes and outputs for all funding requests, which can be monitored and evaluated; Q4 2023/24 introduce new online application system for all funding requests and update guidance for all charitable funding applicants; Q2 2024/25 introduce a more sophisticated online system to monitor and record updates and evaluations from applicants to be included in Charitable Funds Committee reports and charity communications (subject to the approval of new systems Enthuse charity marketing platform, Donorfy CRM, and ProGrant / | Kirsty Thomson, Head of Fundraising : Awyr Las | Russell Caldicott, Interim Executive Director of Finance | 30/09/2023 | 31/07/2024 | 1 |
| 203 | PFIG | Internal Audit | Delivery of Health Board Savings | 2023 | Limited | High | Transformational Savings and the establishment of the Transformational Team | The Health Board: <ul style="list-style-type: none"> 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. | Work continues on development and ownership of transformational savings for the 2024/25 financial year and beyond (as part of planning formation). | The Special Measures deliverable on allocation of the Transformation and Improvement resource is now complete, with available resource being allocated to the Interim Exec Director of Operations and Executive Director of Public Health (MHLD) portfolios. The focus of their work is being driven by these teams to support the organisation's priorities, closer to the point of service delivery. The Portfolio Office continues to support central coordination of Special Measures and will continue to do so. The EDG for Transformation provides oversight of this allocation with a specific remit to ensure that allocations remain aligned with organisational transformational priority. | Update from Paulo Tardivel - The previous update still stands in relation to the part of this recommendation around the role of the Transformation and Improvement team – this part should now be closed. The First part of the recommendation relates to identifying financial savings opportunities and should remain with the Finance team. Update from Russell Caldicott - Update provided as part of savings review by IA Wales | Paula Dixon, Head of Financial Improvement | Russell Caldicott, Interim Executive Director of Finance | 30/04/2023 | 31/07/2024 | 1 |
| 206 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | High | Ligature remediation funding was allocated appropriately | MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk. | Each MH&LD SLT to establish a local Ligature Reduction Group, chaired by the Head of Operations, Vice Chair Head of Nursing with an agreed standardised TOR signed off. To review TOR of the newly established Divisional Ligature Reduction Group, to ensure appropriate membership, meeting frequency and reporting of the group is discussed, agreed and signed off. The Chair of each MH&LD local Ligature Reduction Group to provide an exception report to the Divisional Ligature Reduction Group, covering the following: annual review status, evidence of monthly review risk control and mitigation progress aligned to external review recommendations. The Chair of the Divisional Ligature Reduction Group to provide an exception report to the MH&LD Divisional Service Quality Group (formally MH&LD QSE meeting, Tier 2) and to the MH&LD Senior Leadership Team meeting (formally DSLT Business meeting, Tier 1) to provide assurance on key risks and mitigation plans related to high, medium and low risks to ensure all ligature risk assessments remain subject to regular scrutiny. Chair of the MH&LD Divisional Service Quality Group to provide a monthly assurance report into MH&LD Senior Leadership Team meeting including high risk anti-ligature works for any required capital expenditure. MH&LD Division to commission an external review of all MH&LD inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Each local Ligature Reduction Group to report on progress aligned to the external review report recommendations, included within Chairs exception report feeding into the Divisional Ligature Risk Reduction meeting. MH&LD Division to arrange an audit to check the governance arrangements for anti-ligature are implemented and consistently being met, with an exception report being fed into Divisional Ligature Reduction group highlighting any variance aligned to standards. | The Division has received all external commissioned ligature reports and together with the internal ligature assessments are completing an analysis of high, medium and low scoring ligature items. The Division has held a meeting with Estates and Health and Safety to identify additional ligature items for capital investment/revenue. The Division has completed the fieldwork of the anti-ligature governance audit with a report expected early-mid December 2023. | The Division has a list of high, medium and low ligature risks compiled from external and internal reports. The Division to progress recommendations from the external reports; work to identify those items that require capital and revenue funding remains on-going. | Adrienne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MHLD | 30/06/2023 | 31/03/2024 | 2 |
| 207 | QSE | Internal Audit | MH&LD | 2023 | Reasonable | Medium | Appropriate governance arrangements in place | ToRs require a review for signature and dates, OLM approval of draft ToR, development of a ToR for summit meetings. Formal reporting of information through the tiers is required, consideration needs to be given as using Divisional QSE as an exemplar. Cycle of business needs completion this will underpin any formal reporting requirements form the tiers. | Review TORs highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Summit meeting. MH&LD Finance and Performance Group MH&LD Clinical Strategy Group. To ensure, upon agreement of the revised Cycle of Business, all TORs are reviewed aligned to agreed Governance Framework of the new MH&LD Operating Model. Formal reporting throughout all meeting tiers to be implemented, with all meeting Agenda's amended aligned to agreed reporting structure. MH&LD Cycle of Business populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chair Assurance reports template or Exceptions report template included for reporting throughout tiered governance framework structure. | MH&LD Governance Framework and Reporting Cycle developed and due for approval through respective governance routes. Due for presentation at Operational Leadership Meeting on 07/12/2023, and onward approval at Divisional Senior Leadership Team meeting on 12/12/2023. Once approved, evidence will be submitted and action closed. | MH&LD Governance Framework and Reporting Cycle approval delayed. Due for presentation at Operational Leadership Meeting on 15/02/2024, and onward approval at Divisional Senior Leadership Team meeting on 20/02/2024. Once approved, evidence will be submitted and action closed. | Adrienne Jones, MH&LD Operational Business Lead | Iain Wilkie, Interim Director MHLD | 30/04/2023 | 29/02/2024 | 2 |
| 210 | PFIG | Wales Audit Office | Audit Wales CHC follow-up | 2022 | Reasonable | High | CHC Service Delivery | Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered. | The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development. Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating Model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical and Enabling Services and Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group. | There has been some progress against this action to ensure the Health Board is operating in line with the Framework. Key areas have been reviewed to ensure consistency across the 3 IHCs and Mental Health, and improved processes to provide greater assurance have been implemented e.g. Escalation Process and funding by exception. Further areas for focus have been identified and will be implemented and monitored as part of continued progress. | A number of task and finish groups have concluded on a number of areas to ensure that there is consistency across the 3 IHCs and MH&LD e.g. Placing in Care homes by exception, Disputes process, Training and education. Other workstreams around consistency of approach in regards to complex care, managing back log of reviews, fees queries and section 117 continue. Since the Audit, the executive lead has been confirmed and the work is progressing by identifying work programmes for improvement as opposed to a whole system approach. National work has also commenced in relation to CHC efficiencies, roles, competencies and structures. It is recommended this action target date be extended, continue to embed the improvement programmes and await the recommendations from the national team. | Jane Trowman, Head of Strategy and Health Planning | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/03/2023 | 30/06/2024 | 2 |
| 215 | PFIG | Internal Audit | USC: Urgent Primary Care Centres - Business case outcomes achieved | 2023 | Limited | Medium | Data reconciliation | 3.1 Management to ensure reconciliation of reported performance information to source data is documented and retained. This could be incorporated within existing working documents. 3.2 Health Board to consider using UPCC engagement data to target promotion of the service to GP Practices that have low referral rates / have not used the service. | 3.1 Review of reconciliation data for West and inaccuracies corrected. Confirm management arrangements for reconciliation and retention of performance data for Central IHC UPCC in line with findings and recommendations. Please refer to UPCC Peer review Action Plan – IA2. 3.2 Continuous review of GP practices that have not used the service and meetings/discussions to take place where necessary. Continuous attendance at Practice Managers/Cluster Meetings to promote and provide update of engagement. Review of ED referrals in the West to understand limitations, and consider relocation if proximity to ED is identified as an issue. Please refer to UPCC Peer review Action Plan – IA2 | Update required | This was completed in 2023 and the recommendation was to look for alternative locations outside of the YG site. Unfortunately no suitable alternative locations have been identified and we are currently focusing on the review of the wider UPCC service to consider next steps. Revised implementation date listed in terms of the agreement of future model, with transition to follow. | Chris Couchman, Associate Director of Primary Care | Adele Gittos, Interim Executive Director of Operations | 31/05/2023 | 30/04/2024 | 1 |

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| 216 | PFIG | Internal Audit | USC: Urgent Primary Care Centres - Business case outcomes achieved | 2023 | Limited | Medium | Governance Frameworks and Communication Strategies | 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. | Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality and Safety Group. Please refer to UPCC Peer review Action Plan – IA1 | Update required | An action plan is in place and is reviewed via the primary care leadership team which meets every month. Copy of Service Review Improvement Plan provided as additional evidence for closure | Karen Higgins, Director of Primary Care | Adele Gittos, Interim Executive Director of Operations | 31/05/2023 | 31/03/2024 | 1 |
| 217 | PFIG | Internal Audit | USC: Urgent Primary Care Centres - Business case outcomes achieved | 2023 | Limited | High | UPCC Models | 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. | Future model for Urgent Primary Care being developed currently, led by the Director of Primary and Community Care and Deputy Executive Medical Director for Primary Care. The future model will be established as part of this work. Please refer to UPCC Peer Review Action Plan – IA3 | Update required | Since this work began, advice has been received that the national funding stream for UPCCs will not be available and an exit strategy for alternative models or business as usual must be developed. 30th November initial workshop for all IHCs to discuss the future of UPCC models. Followed by West 25th Jan from which a paper has been circulated to stakeholders. East and Centre TBA. The review of out of hospital urgent care highlighted not only how complex out of hospital urgent care is but how un-necessarily complicated it is. It showed that the complexity is costly and is potentially a cause of under use and inappropriate use of resources. The current action plan supports improvement within the existing model but it does not address the need to redesign a sustainable out of hospital urgent care services that meets needs. February 2024 a working group has been established to develop a business case and a paper is being drafted for Executive discussion. | Karen Higgins, Director of Primary Care | Adele Gittos, Interim Executive Director of Operations | 01/01/2024 | 31/03/2025 | 1 |
| 218 | PFIG | Internal Audit | USC: Urgent Primary Care Centres - Business case outcomes achieved | 2023 | Limited | High | Benefits Realisation | 2.1 Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2 The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated. | 2.1 Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2 Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases. | Update required | Datasets are being used to support activity described in action 217 | Karen Higgins, Director of Primary Care | Adele Gittos, Interim Executive Director of Operations | 01/01/2024 | | 0 |
| 220 | QSE | Internal Audit | Public Health - Smoke free sites | 2023 | Reasonable | Medium | MHLDS Training | MHLDS Division needs to establish how many staff require VBA training. Clarification is necessary on what training is required with regards to talking about the various NRT options to patients. Confirmation by the MHLDS Division that if the contraindications/medical interaction training, is not taking place, what is the requirement to meet objective 15. "Admitting practitioners and other relevant staff are aware of contraindications/interactions of using certain types of NRT". All the above must be reflected in the action plan. | Establish a NRT Training Task and Finish Group to explore and update the 'Guidebook' guidance and recommendation for who needs to complete Level 1 and Level 2 training in MHL Division. This will determine how many staff are required to complete the training. Recommendation from Task and Finish Group to be received by the MHL Division Training and Development Group for ratification and recommendation to Operational Leadership Meeting. The Task and Finish Group to consider training required for NRT options to patients. To include mechanism for recording training data to enable monitor and review. The Task and Finish Group will consider how best to address training, if this is required on contraindications/medical interactions training or if this recommendation is best addressed via completion of audit or distribution of information to raise awareness in the prescribing of NRT. The outcome from 2.1a, 2.1b, 2.1c will lead to development of a training plan for rollout across the Division. Completion of audit to assess awareness of NRT options for patients. Present outcome of audit to OLM to agree recommendations to ensure adherence with policy guidance. | The NRT audit report has been received on 30th November 2023, and will be submitted to the Smoking Cessation Group in December 2023, Clinical Effectiveness Group January 2024 and then a presentation on the NRT audit combined with the Help Me Quit survey at the MHL Learning Event on the 19th January 2024. | The Help Me Quit survey report was received in the summer of 2023. The NRT audit was received towards the latter part of 2023. The NRT audit has been received by the Clinical Effectiveness group in January 2024. The next step is for the NRT audit and the Help Me Quit survey to be presented at the Learning Event in February 2024 by the 2 report authors. | Adrian Jones, Assistant Director of Nursing MHL | Teresa Owen, Health Board Lead for MHL and Welsh Language | 31/01/2024 | 31/03/2024 | 1 |
| 226 | PFIG | Internal Audit | Continuing Healthcare Arrangements | 2020 | N/A | High | R3 | The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by current and new CHC team members. | The CHC corporate team will lead the design of core structures for operational teams at Area and divisional level. This will include standardised job descriptions and structures on teams can work towards locally as opportunities allow within employment law. | Implementation date extended to 31st March 2024 as action is pending national work. | Some job roles have been standardized including the CHC operational managers roles, but other work pending subject to the National work. National work has also commenced in relation to CHC efficiencies, roles, competencies and structures. It is therefore recommended this action be closed / paused - continuing to embed the improvement programmes into business as usual and await the recommendations from the national team. | Kathryn Titchen, Commissioning Manager CHC | Chris Stockport, Executive Director Transformation and Strategic Planning | 31/03/2021 | 30/06/2024 | 12 |
| 227 | PFIG | Internal Audit | Continuing Healthcare Arrangements | 2020 | N/A | High | R5 | The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently. | The Health Board accepts the need for the development of a new 'Commissioning Unit' with the responsibility for the strategic commissioning and performance management of all CHC and ICP placements. The Health Board has agreed in principle to adopt a 'Business Hub' model that will build on these principles, work has commenced to develop an outline business case. | Business Hub design principles have been prioritised and are being built into the current programme of work for Corporate CHC, Finance and Contracting. A weekly Corporate Provider Issues meeting has been established, with a monthly operational meeting to review themes, lessons learnt and identify areas for priority work. SOP provided as additional evidence. Action extended to 31st March 2024. | A number of task and finish groups have concluded on a number of areas to ensure that there is a focus on 'commissioning roles and responsibilities. As there is no resource to establish a bespoke team, Corporate CHC Contracting / Finance / operational teams will continue to support the improvement and efficiency work and embed into business as usual as part of a 'virtual commissioning unit'. Opportunities will be explored as part of staff turn over and development to ensure roles and responsibilities meet current demands and priorities. A number of elements which support the 'virtual commissioning hub' are part of corporate CHC annual work plan. The work plan includes work on: Fee setting and engagement. Pre-Placement Agreement and Individual Placement agreements. Managing the backlog of Reviews. Development of a Care Provider Commissioning strategy. | Kathryn Titchen, Commissioning Manager CHC | Chris Stockport, Executive Director Transformation and Strategic Planning | 30/04/2021 | 30/06/2024 | 10 |
| 230 | PFIG | Wales Audit Office | Structured Assessment (Phase 2) 2021 | 2021 | N/A | High | R1b | Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting. | The business case process is being updated and simplified and will include an assessment of the relative efficiency of the specific service; what action has been considered to improve that efficiency ahead of the business case. | The independent planning review is due to conclude in the last quarter of the calendar year. Part of the governance and planning reviews outcome will be the requirement to review the business case process from an IHC local level to that of an BCU wide business case level with scrutiny panels and committees defined. | Updates provided to QEDG on a quarterly basis. | Pazlo Tardivel, Director of Transformation and Improvement | Chris Stockport, Executive Director Transformation And Strategic Planning | 31/01/2022 | 31/05/2024 | 6 |

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| 235 | PFIG | Internal Audit | Review of Eye Care Services | 2022 | N/A | High | R2 | Sub-regional variation of patient waits: Undertake analysis on sub-regional variation in waits, either by the Health Board's 3 main locality areas or by county of residence. | This links to recommendation 7 (Accountability for eye care service) so that a North Wales view can provide overview, guidance and management utilising the patient treatment list wait information that is already available supported by the dashboards that are in progress. | Update required | Governance established to support necessary service improvements. A Health Board wide eye care improvement group now convenes on a monthly basis to oversee progress. Action can be closed as analysis of variation complete and has informed ongoing improvement work. Copy of update to QSE on Internal Audit Report: "Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists" provided as evidence for closure | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/03/2022 | 31/08/2023 | 6 |
| 238 | PFIG | Internal Audit | Review of Eye Care Services | 2022 | N/A | High | R5 | Efficiencies: Service efficiencies – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans. | Transformation needs to be supported by continuous improvement. There are already key enablers identified with each of the sites/localities developing and agreeing key service productivity improvements pulled together from a pan North Wales to ensure standards are improved and across the Health Board. | Integrated Ophthalmology MDT Local Networks refreshed: with successful delivery of Integrated Retinopathy Pathways, Clinical engagement negatively impacted by continuance of long-term vacancies (Pan BCU Clinical Lead- 12 months. West Clinical Lead >36 months) and variation in appetite for Pan BCU/regional pathways. Shared vision is being supported by Office of Medical Director and Away Days in Q4. | This was originally an area that required Transformational support. However, the work and program have now moved on and is led by the operational teams. Update from Chris Stockport - Eye care improvement group now established with clinical representation to oversee and deliver necessary development of the north Wales service model with subsequent improvement initiatives. | Paolo Tardivel, Director of Transformation and Improvement | Chris Stockport, Executive Director of Transformation and Strategic Planning | 31/03/2023 | 30/04/2024 | 3 |
| 240 | PFIG | Internal Audit | Review of Eye Care Services | 2022 | N/A | High | R7 | Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency. | This will be encompassed within the stronger together work which will require the local integration of acute and primary care services with regards to the vertical pathways and processes whilst there is a North Wales responsibility and accountability for services and decision making to eliminate inappropriate sub-regional variation. It is anticipated that the introduction of a new Optometry reform contract will support change, strengthening relationships but also the opportunity to provide better accountability if delegated to the Health Board. | Update required | Health Board Eye improvement co-ordination group oversees improvement initiatives and prioritisation, supported by the BCU ophthalmology network structure now in place to support service reconfiguration and associated implementation of GIRFT and wider improvement recommendations | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/03/2022 | 30/11/2023 | 7 |
| 241 | PFIG | Internal Audit | Review of Eye Care Services | 2022 | N/A | High | R8 | Eye care clinical leadership: Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure. | Both North Wales Ophthalmology and Optometry Clinical leads are vital to developing and driving improvement. Recently these posts have become vacant and it is key to replace not only these posts but clinical leadership across sites and across the major sub-specialties; this matrix can be reviewed and tested. Vertical leadership creates potential silos whilst a more recent view of pan North Wales pathway leadership could be explored. | Update required | Currently in discussion with a number of potential internal candidates with a view to making an appointment as soon as is practical and given current clinical commitments | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/03/2022 | 31/05/2024 | 6 |
| 244 | Audit Committee | Wales Audit Office | Structured Assessment 2019 | 2019 | N/A | High | R1 | Clinical strategy and service planning R1: Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: Medical staffing, vacancy gaps and on-call rota management. Service efficiency and affordability. Ability to meet forecasted growth in service demand. Mitigate the impact of unscheduled care on the effectiveness of wider services. Enabling sub-specialisation of clinical services, where beneficial. | A digitally enabled clinical strategy has been proposed and extensively discussed at health board meetings in September, October and November 2019. It sets out an ambitious approach to improving population health by focusing on prevention and systems changes, specifically establishing whole-system evidence based pathways; managed professional networks; and implementing a core bundle of digital healthcare technology, e.g. a digital health record. This strategy will disrupt traditional ways of working and enable greater digital literacy. It will build a system that focusses and measures outcomes and places less and less reliance on the site of care, moving to more accessible and personalised care. The strategy will reduce unwarranted variation in practice and outcomes, enhance specialisation and opportunities to improve research partnerships. The strategy will support prudent healthcare and improve the use of resources and maintain an affordable service that meets growth in demand. The Health Board is supporting the development of the strategy, with updates and the final implementation plan due by April 2020. | The clinical services plan will form a part of wider strategy development. Some elements will be developed in the annual plan for 2024/25 that is currently under development | The Clinical Services Strategy went through QSE Committee at the time. Since then discussed with EMD and AD of Transformation whose view is seeking to close this action as a clinical services strategy was developed and there have been various changes in leadership where the strategic context and approach has been reset since this action was taken in 2019 | Nick Lyons, Executive Medical Director | Phil Meakin, Interim Board Secretary | 31/07/2020 | 01/12/2023 | 11 |
| 247 | People Committee | Internal Audit | Recruitment of Substantive and Interim Executive and Senior Posts (ESP) | 2023 | Limited | High | Appointment of substantive JESP/VSM Posts | Management must ensure all appointments to JESP/VSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders. Management ensure that mandatory procurement training is in place for all Executive Directors and all staff involved in procurement, as required by Welsh Government Chief Executive, NHS Wales. | A new standard operating procedure, linked to a new WPI safe recruitment policy, for all JESP/VSM appointments will be implemented. The new SOP will encompass reporting of compliance relating to Welsh Government instructions and Health Board standing orders, and will detail the lead officer for each area of responsibility. A new procurement training competence will be added to all JESP/VSM positions into ESR which will link to the training course needed to acquire the competence. This will be visible alongside all mandatory training for senior managers and enable effective reporting alongside all training requirements for the individuals. | The new SOP for VSM appointments has been approved through the policy development group and is expected to be ratified at the next REMCOM meeting in January 2024. The SOP became operational in August 2023 pending ratification. Procurement training for Executives has commenced and is due to be completed by the end of January 2024. | The SOP did not get on the agenda for the January REMCOM and will be presented now at the March REMCOM. There are still a number of outstanding Executives that require training and this will be resolved by end of February 2023. The implementation date will need to be amended to March 24 now. | Ali Mirza, Head of Strategic Recruitment | Jason Brannan, Deputy Director of People | 31/07/2023 | 31/03/2024 | 3 |
| 252 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Board Assurance Framework | The process for reviewing and updating the BAF should be documented and implemented. The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions. The sections of the BAF should be fully completed. The level of detail in action plans should be reviewed to ensure there is sufficient information included to provide assurance to members that appropriate actions are in place to address risks identified. | Document the process for reviewing and updating the BAF with implementation date. Ensure objectives of the Health Board is incorporated into the BAF with focused actions. It is paramount that all sections of the BAF be completed for robust scrutiny and assurance. (see action 3.4 below). Review the action plans to ensure sufficient information is included in the BAF with appropriate actions. | The Board Assurance Framework has been completed along with action plans however is aligned to priorities and not objectives. This can be closed once objectives are reviewed in February. | Work is now underway on the key strategic objectives for the Health Board to adopt by 2024 (April) and a draft set has been identified that will be shared with Board members through the development of the Health Boards Annual Plan. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | 30/08/2023 | 31/03/2024 | 2 |
| 254 | Audit Committee | Internal Audit | Risk Management and Board Assurance Framework | 2023 | Limited | High | Oversight and scrutiny of Divisions / IHCs | Review of all meetings attended across the three areas by the Risk Management Department is required. This will give a better understanding of what meetings are taking place as well as providing a more consistent and robust approach towards the Divisions/IHCs risk management arrangements. Clarification required on how the West IHC will provide assurance on its risk management arrangements without a IHC meetings Risk Management Group meeting taking place. | At the Risk Team Meeting, Regional Managers were asked to produce an excel spreadsheet of meetings which review and scrutinise risks for the rest of the year. Any cancellation of meetings and reasons why to be fed back during the Risk Team with repeat cancellation of meetings for escalation to the AD of Governance. Regional Manager West is working with West IHC to provide assurance on its risk management arrangements without the Risk Management Group meeting taking place. Meeting arranged with IHC Medical Director, Interim Head of Risk Management and Regional Manager West on the 1st June 2023 for further discussion and action (additional IA comments to the Management Response - Actions will need to be reviewed following the outcome of the meeting on 1st June 2023). | All meetings have been mapped by the team but this needs to be signed off by the Head of Risk Management before closing. | All meetings have been mapped by the team and signed off by the Head of Risk Management before closing. Additional evidence in the form of Risk Meeting tracker provided to support closure. | Nesta Collingridge, Head of Risk Management | Phil Meakin, Interim Board Secretary | 30/08/2023 | 28/02/2024 | 3 |
| 256 | PFIG | Internal Audit | Planned Care Recovery and Transformation Group | 2023 | Limited | High | Planned Care Recovery and Transformation Group | It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented. | A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July. Programme resources have been identified and we are working to appoint individuals into lead roles. | Update required | Planned Care Programme established with agreed governance, meeting every 6 weeks. Copy of Programme Board TORs provided as additional evidence for closure | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/07/2023 | | 0 |
| 257 | PFIG | Internal Audit | Planned Care Recovery and Transformation Group | 2023 | Limited | High | Reporting | Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups/Committees. | Reporting arrangements will be published once finalised with the programme initiation arrangements. | Update required | ToR to be ratified at Primary Care Programme Board March 2024 | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/07/2023 | 31/03/2024 | 1 |

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| 258 | QSE | Internal Audit | Data analysis – Triangulation of data | 2023 | Limited | High | Triangulation of Data sets using consistent naming conventions | The Deputy Director of Quality: Continues to support the Quality Lead Manager develop the use of all data quality sets to inform Health Board wide reporting – This should be a priority. Ensures the standardisation of 'Location' within Datix, reviews the data associated with 'Do Not Use' and removes duplication of 'Categories', ensuring an appropriate audit trail where these are amended. Considers and progresses the findings within Paragraphs 2.3 to 2.5 inclusive of the Detailed Findings. | Following on from the re-alignment of the quality functions, a new Quality Insight and Systems Team is being created. New standard operating procedures for quality systems such as Datix are being developed which will include standardisation of analysis, reporting and dashboards. Working with the national Once for Wales RLDatix Team, a new locations and services hierarchy was implemented in April 2023 which aligns to national standards under the Once for Wales RLDatix programme and best practice. A change control process will be in place via the SOPs mentioned above. The findings from internal audit will be reviewed with the respective quality governance teams and findings will be shared with the executive-chaired Quality Delivery Group. | Draft Dashboard will be in place for end of November 2023. | The new team is in place and all posts filled permanent or on internal secondment. A quality systems group is in place with representatives from key teams. The group provides central coordination of system development and approved all system changes. Meeting pack as of the Quality Systems Group provided as further evidence. | Matthew Joyes, Assistant Director of Patient Safety and Experience | Angela Wood, Executive Director of Nursing and Midwifery | 31/08/2023 | 31/11/2023 | 1 |
| 259 | QSE | Internal Audit | Data analysis – Triangulation of data | 2023 | Limited | High | Template minimum data sets | The three Clinical Executive Directors stipulate the minimum quality and safety data sets for regular reporting across the Health Board, with respective Clinical Directors determining the remaining service specific data required. The Deputy Director of Quality should ensure the minimum quality and safety data sets are consistently used across all IHCs and Divisions. | A standardised organisation-wide Quality Dashboard is under development. A Workshop will be held with members of the Quality Delivery Group to agree the content of reporting from IHC/Divisional quality groups to the executive chaired meeting. This will inform reporting requirements throughout the quality governance structure. Once the above is agreed by the workshop and executive-chaired Quality Delivery Group, standard templates will be issued to divisions. | The Clinical Governance Review as part of Special Measures has not yet commenced and this work will be done as part of that review process with support from the national team: deadline therefore extended to 31/03/2024. | Work continues as per the previous update. The draft dashboard is in place and being further refined, including validating the data fields. An initial automatic data feed into the warehouse has not been established. | Matthew Joyes, Assistant Director of Patient Safety and Experience | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2023 | 31/03/2024 | 1 |
| 260 | QSE | Internal Audit | Data analysis – Triangulation of data | 2023 | Limited | High | Quality, Safety and Experience Committee reporting | The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes. | Following changes within the Board arising from Special Measures, the new members of the Committee are working with the Executive Director of Nursing and Midwifery (as executive lead for the QSE Committee) to revise the committee terms of reference and cycle of business. As a result, the reporting expectations and requirements will be revised. The special measures reviews of patient safety and quality governance systems by the Independent Special Advisors will also inform this work. | This action to remain open until after the December QSE meeting, that way we can provide the final cycle of business and minutes as evidence to support closure. | The QSE terms of reference and cycle of business, including standard reports as revised and approved by Board in January 2024. | Matthew Joyes, Assistant Director of Patient Safety and Experience | Angela Wood, Executive Director of Nursing and Midwifery | 30/09/2023 | 31/12/2023 | 1 |
| 261 | QSE | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High | Process management | Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined. | The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning performance management, business intelligence/analysis and other professional services that input to contract management both where the health board is commissioner and provider. The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. (Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight). | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | Adrian Tomkins, Associate Director of Healthcare Contracting | Angela Wood, Executive Director of Nursing and Midwifery | 31/08/2023 | 31/03/2024 | 2 |
| 262 | QSE | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High | Contractual obligations | Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement. | The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective. | The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establishing the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective. | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | Adrian Tomkins, Associate Director of Healthcare Contracting | Angela Wood, Executive Director of Nursing and Midwifery | 31/08/2023 | 31/03/2024 | 1 |
| 263 | QSE | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High | Quality measures (a) | Management to review contractual quality measures to ensure they are robust, effective, and appropriate. | For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements (by 30/08/23). The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025 (by 31/03/2024). The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner/CQC (by 31/07/2023). | For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements (by 30/08/2023). The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025 (by 31/03/2024). The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner / CQC (by 31/07/2023). | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | Adrian Tomkins, Associate Director of Healthcare Contracting | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2024 | | 0 |
| 264 | QSE | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High | Quality measures (b) | Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures. | The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required. | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Exec Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Exec Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | Adrian Tomkins, Associate Director of Healthcare Contracting | Angela Wood, Executive Director of Nursing and Midwifery | 31/10/2023 | 31/03/2024 | 1 |

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| 265 | QSE | Internal Audit | Contracted Patient Services: Quality and Safety Arrangements | 2023 | Limited | High | Board assurance | Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny. | The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF (by 31/10/2023). The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation routes (by 31/08/2023). | The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required. | The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement. | Adrian Tomkins, Associate Director of Healthcare Contracting | Angela Wood, Executive Director of Nursing and Midwifery | 31/10/2023 | 31/03/2024 | 1 |
| 267 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | High | Procedures | 1. Standard Operating Procedures should be in place for the process of collating information for the performance reports, including: - Roles and responsibilities (Performance staff, informatics, other staff providing data) - Data quality standards/consistent metrics/imescales - Data collation – process for receiving/extracting and collating data (including systems used and any training required for these) - Data validation – details of checks to be undertaken 2. Further work is required to provide assurance to the Board that the actions stated in performance reports are improving performance/outcomes. | 1. The proposed establishment of a working group between Performance and Informatics colleagues is being developed – the first meeting of this meeting will focus on the process of external reporting of data, alignment with Wales Digital reporting guidance and other data definitions used within the NHS Wales Operating Framework and Welsh Government Aims. The remit of the Group will include all of the recommendations made in this report. 2. Agreed – The documents editor has the responsibility to ensure all avenues of intelligence and assurance are incorporated into the analysis and reporting including external assurance if available. | Once the IPR is ratified at Health Board on the 30/11/2023, the Performance Intelligence and Assurance Directorate will produce the Standard Operating Procedures required to ensure efficient and accurate replication of the reports for updates as required. The Standard Operating Procedures will be tested and the Directorate will encourage a review by internal audit to ensure that they are robust and appropriate for a business continuity plan. | Procedures for data capture can be evidenced by the Director of Performance, the reporting cycles now in operation following endorsement of the Performance Framework. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | 31/03/2024 | | 0 |
| 268 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | High | Accountability meetings (a) | The Health Board continue with the improvement plan to review and update Performance and Accountability Framework, ensuring meetings are scheduled regularly and the information discussed in performance meetings is captured, with expected outcomes clearly communicated to senior managers. | Agreed – Interim Director of Performance working closely with Interim CEO to agree/consult on direction of travel. Underway and first draft anticipated Q2, 2023/24. | Integrated performance Reviews have been put in place and will be held between 18th December 2023 and 22nd January 2024. | Executive Delivery Integrated Performance Group now embedded within the HB, reporting throughout and external to HB completed. Additional evidence of Group TORs, action log and minutes provided to support closure. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | 31/03/2024 | | 0 |
| 270 | PFIG | Internal Audit | Performance Management – Quality and Performance Reporting and Accountability Arrangements | 2023 | Limited | High | Accountability meetings (c) | The process for reviewing actions should be revisited, to ensure actions from meetings are SMART, and progress is regularly provided (with reference to further detail in meeting minutes as required) | This action will be aligned with the revised PAF process for Q2 Reviews, scheduled for Sept 2023. | The Integrated Performance Strategy for 2023-27 will outline the communication routes with regards accountability reviews. This will include the structure and process around recording and communicating the actions and outcomes of the reviews. There will be a clear escalation process and pathway ensuring escalations reach the appropriate forum, e.g. QSE, PFIG. They will also ensure timely communication and feedback to the services being held to account, with clear SMART actions. Progress of such actions will be monitored by the Performance Intelligence and Assurance Directorate outside of the reviews to ensure progress and updates are available at the next review. | Accountability meetings are the Integrated Performance Reviews, cancelled owing to Industrial Action. The DoP, EoF and CEO are reviewing the ToR for the IPRs and will have the dates set for the next financial year, by 31st March 2024. Whilst initial meetings occurred for some areas, they were chaired by relevant Operational Director and the meetings need to develop focus to hold services accountable for delivery. This is to be considered in the review of how these meetings progress. | Edward Williams, Acting Director of Performance | Russell Caldicott, Interim Executive Director of Finance | 30/09/2023 | 30/06/2024 | 2 |
| 273 | QSE | Internal Audit | Hergest Unit Notice of Contravention (NoC) Action Plan | 2023 | Limited | High | Action Plan evidence | The action plan evidence is reviewed immediately and updated to demonstrate all actions are embedded both at Hergest, with wider assurance to the Health Board on practice across the Division | The Notice of Contravention (NoC) Group will continue until just after the revised Court hearing (postponed from 03.08.2023) and will take forward the findings of this internal audit to direct further work and provide further evidence, as well as ongoing monitoring arrangements and intervention where recovery actions are required. Post-hearing, the NoC Action Plan (and Group) will be transferred to the Special Measures NCCU Action Plan and associated leadership/assurance arrangements to ensure alignment with the inpatient quality and safety programme, the special measures programme and to ensure ongoing sustainability of the actions. | HSE NoC Action plan evidence has been expanded to provide additional MH&LD Divisional activity aligned to the three material HSE Breaches. This will be provided by Teams due to the size of the documents. In addition, a Divisional wide HSE NoC Audit has been completed with additional layers of governance, audit methodology and incorporating lessons learnt from previous HSE NoC audit activity to demonstrate the ongoing journey of improvement across all areas of patient care. The court hearing has been rescheduled to the 18th December 2023, after this time the division will be in a more informed position. The narrative contained in the response column remains accurate and will be updated after the court hearing. | The HSE NoC court hearing occurred on 18th December 2023. The outcome of the court case was a fine of £200,000 with £13,000 court costs. As agreed by Divisional, Corporate and Welsh Government the NoC Action plan has been transferred to the National Collaborative Commissioning Unit (NCCU) Action plan with the associated leadership, governance and assurance arrangements in place to ensure the Division continues on their improvement journey. The NCCU Inpatient Safety Delivery Group continue to meet fortnightly to progress the actions of the NCCU Action plan aligned to the eight recommendations made from the NCCU and NHS Executive Inpatient review undertaken during May 2023. A MH&LD Update report on progress of the action plan has been submitted through due Governance and submitted to the NCCU and NHS Executive, who are due to undertake a Follow Up Review during February 2024. The overall aim of the Follow Up Review will be to observe and evidence where improvements have been made and sustained and outstanding actions have been completed or are progressing towards completion. Action to be marked as complete | Iain Wilkie, Interim Director MHLd | Teresa Owen, Health Board Lead for MHLd and Welsh Language | 31/10/2023 | 31/01/2024 | 1 |
| 276 | PFIG | Internal Audit | Accounts Receivable | 2023 | Reasonable | Medium | Financial Procedures | Management review and update relevant financial procedures as necessary to ensure they are fit for purpose | The updating of financial procedures is part of the Financial Control Environment Action Plan. Those requiring review will be prioritised and brought up to date as required. | Reasons for delay: • The audit of the 2022-23 annual accounts took a month longer than originally planned in the Welsh Government timetable and was not completed until the end of August; • Rather than looking at a standard update of the existing financial procedures we are carrying out a larger review to consider whether any can be consolidated or simplified which will take longer but will result in more user-friendly documents. November update: "The four financial procedures have now been drafted and a meeting is being arranged with the Policies Team to agree the necessary consultation and approval processes before the procedure can be adopted". It is expected that implementation will be January 2024. | A review programme has been established to refresh the Financial Policies, with consideration being given to re-assessing those as local procedures, as appropriate. The first two policies are currently out for local consultation, with the next two due to be consulted upon in late February | Simon Weaver, Head of Financial Control | Russell Caldicott, Interim Executive Director of Finance | 30/09/2023 | 28/02/2024 | 1 |

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| 284 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | Medium | Process Management (1.1) | Management to develop robust written control documents to support operational processes and strengthen governance arrangements. | Agree with recommendation. Management will develop robust written control documents to support operational processes and strengthen governance arrangements. Much of this will be incorporated into 1.2 Terms of Reference. | Update required | This action is completed. A terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group. Copy of action plan provided as additional evidence for closure | Rachael Page, Assistant Director of Primary Care | Adele Gittoes, Interim Executive Director of Operations | 13/10/2023 | | 0 |
| 285 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | Medium | Process Management (1.2) | Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making. | Agree with recommendation. Management will establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making. | Update required | This action is completed. A terms of reference has been finalised and decision making is documented. Minutes from monthly meetings will be recorded and an action plan is in place. Copy of action plan provided as evidence | Rachael Page, Assistant Director of Primary Care | Adele Gittoes, Interim Executive Director of Operations | 13/10/2023 | | 0 |
| 286 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | Medium | Process Management (1.3) | Management to review implemented improvement actions to ensure they are operating as expected/having the desired impact. | Agree with recommendation. Management will review implemented improvement actions to ensure they are operating as expected/having the desired impact. | Update required | This action is ongoing and in process. As actions are completed they will be monitored by the Primary Care Team. The outstanding actions will be monitored closely and will be reviewed when completed to ensure they are operating as | Sefton Brennan, Head of Service GPOOH | Adele Gittoes, Interim Executive Director of Operations | 20/10/2023 | 31/03/2024 | 1 |
| 287 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | Medium | Progress Update Log | Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the Progress Update Log is currently being reviewed – management should consider the appropriateness and current utilisation of the Evidence field within the Update Log. | Agree with recommendation. Management will ensure that responsible officers and completion dates assigned to improvement actions are documented. Management will consider the appropriateness and current utilisation of the Evidence field within the Progress Update Log. | Update required | This action is completed. Completion dates and improvement actions are now monitored via the action plan for the group. Responsible officers have been identified for each action. The evidence field and update log are incorporated onto the action plan. Copy of action plan provided as evidence | Rachael Page, Assistant Director of Primary Care | Adele Gittoes, Interim Executive Director of Operations | 13/10/2023 | | 0 |
| 288 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | High | Data Discrepancy | Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. | Agree with recommendation. Management will clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. The BCU team will work with the national team to agree on the content and presentation of the appropriate data sets. | Update required | Investigation into data discrepancy has shown that the Health Board GPOOH data is accurate. The National Team had applied floored formulas in accumulation of data, and were also not using the same filter set to ensure accurate data collection. It was also found that a report used by the national team was not pulling the full data required on certain fields that was being captured by the GPOOH team. A request is with Adastra to correct this but has been delayed due to the contract agreement only in place from 1st January. HB GPOOH Team and National Team will continue to work together to ensure the remote data being pulled is uniformly accurate. The HB have Asked Adastra for an update on the report fix, and therefore have revised the implementation date to allow for this. Following this, it will be an ongoing piece of work to check month on month. | Sefton Brennan, Head of Service GPOOH | Adele Gittoes, Interim Executive Director of Operations | 27/10/2023 | 31/03/2024 | 0 |
| 289 | PFIG | Internal Audit | GP Out of Hours | 2023 | Limited | High | Board Assurance | Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. | Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team. | Update required | This action is ongoing and in process. Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review. | Rachael Page, Assistant Director of Primary Care | Adele Gittoes, Interim Executive Director of Operations | 27/10/2023 | | 0 |
| 290 | QSE | Internal Audit | Falls Management | 2023 | Limited | Medium | Policy (Design) | 1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway. | 1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Review/consultation by Health Board Inpatient Falls Steering group | Draft Policy out for consultation with Falls Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. | Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 30/11/2023 | | 0 |
| 291 | QSE | Internal Audit | Falls Management | 2023 | Limited | Medium | Policy (Design) | 1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway. | 1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Approval required by the Health Board Patient Safety Group | Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. | Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 30/11/2023 | | 0 |
| 292 | QSE | Internal Audit | Falls Management | 2023 | Limited | Medium | Policy (Design) | 1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway. | 1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on Betsinet. | Out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. If approved by PSG, this action will then be completed. | Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 31/12/2023 | | 0 |
| 294 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. | 2.1a How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards; | Good practice examples shared pan BCUHB alongside ongoing peer review process. | How to guide shared across all IHC's. Evidence relating to Falls Programme provided to support closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 30/11/2023 | | 0 |
| 295 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. | 2.1a In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model. | Good practice examples shared pan BCUHB alongside ongoing peer review process. | Complete: How to guide with peer review process shared across all IHC's evidence of peer review process via metrics and IHC reporting templates. How to guide developed for Agency worker shared with temporary staffing. In addition Accreditation team are delivering training to Student Nurses within both Universities regarding FBHMA and Patient Handling Risk Assessments. To date over 150 Student Nurses have completed training session. Evidence relating to Falls Programme provided to support closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 01/02/2024 | | 0 |

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| 296 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) | 2.1b To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered. | The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: -The Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile. | Auto population dependent on All Wales schedule, however risk mitigated via training resources and peer review process. | Ongoing national agenda: This is part of the national agenda, Health Board representative CND aware of the recommendation and represent Health Board. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 01/02/2024 | 30/04/2024 | 1 |
| 298 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1a To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. | Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce. | The Manual handling Advisors are undertaking a monthly visit to wards identified as high risk for falls based on datix data. This programme is working well in Central and in the East and due to sickness there has been a delay with establishing this programme in the West. MH Trainers also attend wards to check compliances if training classes are cancelled or reduced size requiring only one trainer. It should be noted that the MH bedside learning programme is limited to the one visit a month, there are other teams that also provide this learning though and this may benefit from a coordinated response. | FBHMA is discussed during all training delivered by the Manual Handling team. Each region of the Health Board is supported by a dedicated Manual Handling Advisor who is instructed to deliver falls bedside learning at least once per month. This workstream is monitored by the Manual Handling Manager and forms part of the teams annual KPI's. Due to sickness in Q2 & Q3 2023/24 operational demand has resulted in Manual Handling Advisors supporting the wider team with the delivery of all other aspects of Manual Handling training. | Sue Morgan, Head of Health, Safety and Security | Angela Wood, Executive Director of Nursing and Midwifery | 01/01/2024 | 31/03/2024 | 1 |
| 299 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1b Review Safeguarding training to include post falls management. | Internal training facilities to be identified by each IHC by December 2023. MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023. | Identified BCUHB training rooms have been identified in BCUHB sites including BYN, Abergele and the CTU in Wrexham. Moves are scheduled in the diary to take place by the end of 2023. | Conversations are being undertaken to ascertain the possibility of incorporating post falls management into Safeguarding training via the All Wales Safeguarding Group. Local implementation of this incorporation will commence in April 2024 | Sue Morgan, Head of Health, Safety and Security | Angela Wood, Executive Director of Nursing and Midwifery | 30/12/2023 | 30/04/2024 | 1 |
| 300 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1c Consider a more formal training method for the bedside learning programme, and consider resources required to provide this staff. Ensure records of training are kept. | Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals. Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls. | Email reminders are being sent to staff four weeks prior to them attending their course and then a week before. Any delegates who do not attend (DNA) are sent a survey to establish the reason so that this can be captured in future training plans. The team are in the process of setting up the text message reminders. Level 2 training remains an eLearning package centralised to Welsh government, the package does not directly talk about falls but does support staff of when to consider an adult at risk. There is a guidance framework that is available for staff to refer to in relation to falls and safeguarding. This has also been adopted by the North Wales Safeguarding Board. | Regarding the bedside learning and training challenges in Patient Handling due to vacancies and absence rates within the Patient Handling and Health & Safety team. This has been added to the Risk Register. Alternative support is being sourced from practice development teams. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 01/04/2024 | | 0 |
| 301 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Training (Operation and Design) | 3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. | 3.1d Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls. Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health and Safety team. | Safeguarding matrix included in updated policy (with Steering Group for consultation before going to BCUHB PSG for ratification on 30/11/23). Agencies provided with access to Falls training on NHS Wales e-learning site. Monthly monitoring in place for completions. | Following the HSE report, a process has been implemented where agencies are able to request accounts for learning@wales for their workers who are active in BCUHB to enable them to complete Falls modules on this platform. However, we do not on-board any workers, and have not since October, without some form of falls training having been completed via the Agency and we advocate once on-boarded they must complete the falls modules via learning@wales platform. Some agencies have reported a backlog in their workers receiving their login information and we are following this up with the team. Evidence to support closure provided. | Clair Tipton, Head of Digital Workforce and Resourcing | Angela Wood, Executive Director of Nursing and Midwifery | 01/12/2023 | | 0 |
| 303 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1a The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls. | 4.1a The revised Health Board policy NU06 outlines the following process for inpatient falls to support identification of themes, trends and learning as follows: - Hot debrief on the ward following the fall for immediate learning and mitigation; - All falls are reviewed daily by local quality teams; - All falls are subject to focused review contained within Datix system; - All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; - All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. - The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings. | Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. | Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. This action can be closed as copy of 'NU06 - The Prevention and Management of Adult In-Patient Falls Policy - V5.0' provided as additional evidence. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 01/12/2023 | | 0 |
| 304 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section. | 4.1b Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs. | SOP to be developed. | SOP in final stages of development as best practice guide and flow chart to support weekly meetings. The IHC's are currently testing the use of Crib sheet to support Falls reviews, learning and sharing. A member of the Patient Safety team attends IHC weekly meetings to support the process and offer additional IHC support. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 30/12/2023 | 30/03/2024 | 1 |
| 306 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section. | 4.1b Action 3 - The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 2023 and will be an ongoing programme of training and support across the Health Board. | Incident management training sessions have commenced face to face on the acute sites. Weekly dates are arranged up until end of March 2024 and include face to face and virtual sessions. Further dates will be commissioned. Training advertised on Betsinet, Nursing newsletter and disseminated to governance leads. | Weekly dates are arranged up until end of March 2024 and include face to face and virtual sessions. Further dates will be commissioned. Training advertised on Betsinet, Nursing newsletter and disseminated to governance leads. Evidence of training posters provided to | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 20/11/2023 | | 0 |
| 307 | QSE | Internal Audit | Falls Management | 2023 | Limited | High | Governance (Operation) | 4.1c Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements. | 4.1c The ward accreditation metrics are currently under review as part of the Health Board Ward Accreditation review. The revised metrics will be tested across the Health Board Inpatient wards to confirm the appropriateness and level of detail within the metric. | Aiming for April 2024 relaunch of Accreditation programme. | Proposed new Ward Accreditation metrics are being used for the supportive visits to wards to establish areas requiring additional support for wards prior to the relaunch of Accreditation programme later this year launch date to be confirmed. Health Board DDAT team are currently developing a data capture tool that will link in with HB Quality Dashboard and will enable wards to provide evidence against the Accreditation metrics. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | 01/04/2024 | | 0 |

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| 308 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | WG initiated, locally delivered tranche 'patient' validation exercise (Operation) | The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application | Action 1 - The Health Board recognises the need to improve upon and modernise the governance arrangements and management of validity of data and cleansing the waiting list. Funding was recognised as being required to address and strengthen the governance and management of the waiting lists. | The Health Board has now implemented WPAS (Welsh Patient Administration System) which provides us with a validation dashboard so we no longer use spreadsheets to manage data. The Health Board was successful in a bid against national planned care recovery and sustainability fund to strengthen booking processes and develop an in-house validation capability. This includes ongoing tranche validation work with plans to have a dedicated substantive validation team in place by start of 2023-24 financial year. At that point, validation will transition to business-as-usual rather than a cohort or tranche activity. Tranche validation work is currently underway together with recruitment of a substantive validation team that we anticipate being in post by the start of the new financial year. This action remains in progress. A revision has been made to the implementation date and it is anticipated that this will be complete by 31/03/2024 and will be business as usual. | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/07/2022 | 31/03/2024 | 1 |
| 309 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | WG initiated, locally delivered tranche 'patient' validation exercise (Operation) | The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application | Action 2 - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG (Welsh Government) who have engaged on the initiative with a view to scaling up pan-BCU (Due by 30/09/2022). The proof of concept to digitize and automate elements of the validation process is underway as part of the funded business case to establish a validation team. | As per response to Action 1 (tracker ID 308). Tranche validation work will cease at the end of this financial year (March 2024) and move to business as usual through a substantive in-house validation team. This action remains in progress. | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 30/09/2022 | 31/03/2024 | 1 |
| 310 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | WG initiated, locally delivered tranche 'patient' validation exercise (Operation) | The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application | Action 3 - Service validation model will be reviewed and redesigned as a component part of implementation of the substantive validation team, as part of the shift to business-as-usual processes under Action 1. | This action remains in progress to business-as-usual processes under Action 1 (referred to as ID 308 in this tracker). | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | Rhys Blake, Associate Director of Planned Care | Adele Gittoes, Interim Executive Director of Operations | 31/03/2023 | 31/03/2024 | 1 |
| 311 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) | Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm | Action 4 - The Health Board recognizes the critical importance of risk stratification for overdue patients to minimize risk of patient harm. With the discontinuation of manual P value assignment under previous COVID protocols as noted in Actions 4 and 5, risk stratification now follows standing Welsh RTT guidance. A project is underway as part of the Planned Care Programme (see Action 7) to automate risk stratification based on referrals exceeding defined waiting time thresholds for their RTT classification. Automatic alerts will be generated for booking teams to facilitate urgent clinical review, re-prioritization, and escalation if needed. This multi-pronged approach will significantly strengthen oversight and proactive management of risk associated with overdue patients. Regular reporting will occur through the Planned Care Programme governance noted previously. | P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine. | This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed. | Site Directorate General Managers | Adele Gittoes, Interim Executive Director of Operations | 30/04/2022 | | 0 |
| 312 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) | Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm. | Action 5 - P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine. | P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine. | This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed. | Site Directorate General Managers | Adele Gittoes, Interim Executive Director of Operations | 31/05/2022 | | 0 |
| 313 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) | Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm. | Action 6 – Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting. | Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting. | These figures are submitted to WG on a weekly basis and also discussed in the weekly access meetings. The validation exercise had concluded. Long waiting patients (named Extreme Waits) are monitored weekly through Corporate Access (following local IHC access weekly meetings that inform Corporate Access) with weekly updates provided to Welsh Government. As well as this (the monitoring of Extreme waits) the health board also reviews weekly Treat in Turn and the reduction of long waits this being >104 week waits and new outpatient referrals >52 weeks. As part of data quality, the health board has a continuing cycle of validation, this consisting of a two phased approach (data, and two stage patient contact) that has both clinical and | Site Directorate General Managers | Adele Gittoes, Interim Executive Director of Operations | 31/03/2022 | | 0 |
| 314 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) | Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm. | Action 7 – The Health Board recognizes the importance of aligned standardized removal reasons across all sites for consistency, improved analysis, and reduced errors or inconsistencies. Significant progress has already been made through the system consolidation actions updated below. Implementation of a single centralized Welsh Patient Administration System (WPAS) instance has established consistent removal coding structures across all Health Board sites and user groups. The migration to a unified WPAS platform with standardized data structures has eliminated the need for interim data alignment. By virtue of progress under Action 8 (action ID 315 in this tracker), removal reasons are now consistent organization-wide. With WPAS system convergence complete, the Health Board now has a single integrated structure for patient administration, referrals, waiting list management, and removals management. Standard operation procedures will reflect the centralized data system. This will further consolidate the gains from technical system consolidation to support consistency in removal reason usage. Progress will be monitored through Informatics governance. | A formal Planned Care Programme has been established which reports into an Executive Chaired Programme Board and ultimately onward to Executive Team. This board oversees progress against identified work streams and associated developments of which validation, booking and referral is a key programme of work. Operational progress around performance and delivery against RTT targets is monitored through weekly corporate access meeting. The recommendation will remain open until the automated, sustainable process is fully implemented by March 2024. | A formal Planned Care Programme has been established which reports into an Executive Chaired Programme Board and ultimately onward to Executive Team. A copy of the TORs for this Programme is attached as additional evidence for closure. | Site Directorate General Managers | Adele Gittoes, Interim Executive Director of Operations | 31/03/2022 | 30/06/2024 | 1 |
| 315 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 3 - Patients removed from waiting lists (Operation) | Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors. | Action 8 – The Health Board has completed the implementation of a single instance of WPAS which closes this action. | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | WPAS Standardisation lead | Adele Gittoes, Interim Executive Director of Operations | May 2022 | | 0 |

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|-----|------|----------------|---|------|---------|------|---|---|--|---|--|--|--|------------|---|---|
| 316 | PFIG | Internal Audit | Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists | 2022 | Limited | High | Matter Arising 3 - Patients removed from waiting lists (Operation) | Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors. | Action 9 – As per action 8 (ID 315 in this tracker) – completed and closed. | As per action 8 (ID 315 in this tracker) – completed and closed. | The Health Board has completed the implementation of a single instance of WPAS which closes this action. | WPAS Standardisation lead | Adele Gittos, Interim Executive Director of Operations | July 2022 | | 0 |
| 317 | PFIG | Internal Audit | Decarbonisation | 2023 | Limited | High | Matter Arising 1: Governance Structure (Design), Monitoring & Reporting (Operation) | In accordance with the NHS Wales Decarbonisation Strategic Development Plan 2021–2030, establish appropriate, robust, and effective governance frameworks to implement the Health Board's Decarbonisation Action Plan to achieve net zero carbon emissions by 2030. | As articulated in the findings of the report the Health Board has formed an appropriate governance framework. The six subgroups formed aligns to the national recommendations and reports into the DPB which will then report to PPPH and the Board receiving assurance from this sub-committee. There is an acceptance of the infancy in which this framework has been formed and we will need to ensure the sub-groups offer the appropriate level of assurance to the DPB. The Decarbonisation Programme Board will ensure a formal governance framework is defined and agreed through the Terms of Reference. In addition this will align to the overall organisational governance structure, with reporting to PPPH once re-convened. | Governance framework enacted for 2024/25 with addition of PPPH Health Board sub-committee to oversee work in this area and highlight improvements made and risks to delivery accordingly. | Russell Caldicott, Interim Executive Director of Finance and Programme Lead | Russell Caldicott, Interim Executive Director of Finance | 31/05/2024 | 31/07/2024 | 1 | |
| 318 | PFIG | Internal Audit | Decarbonisation | 2023 | Limited | High | Matter Arising 1: Governance Structure (Design), Monitoring & Reporting (Operation) | Ensure that the Health Board has suitable reporting systems in place to provide continuing assurance on the progress of the decarbonisation action plan. | As articulated in the findings of the report the Health Board has formed an appropriate governance framework. The six subgroups formed aligns to the national recommendations and reports into the DPB which will then report to PPPH and the Board receiving assurance from this sub-committee. There is an acceptance of the infancy in which this framework has been formed and we will need to ensure the sub-groups offer the appropriate level of assurance to the DPB. The Decarbonisation Programme Board will ensure a formal governance framework is defined and agreed through the Terms of Reference. In addition this will align to the overall organisational governance structure, with reporting to PPPH once re-convened. | The Health Board has reestablished the PPPH Board and the Decarbonisation Programme Board will be producing regular update reports as per the recommendation. There is still internal discussions on the final governance and accountability structure, and therefore the full implementation of the subgroups have been slightly delayed. Evidence relating to the PPPH provided as evidence to support closure. | Russell Caldicott, Interim Executive Director of Finance and Programme Lead | Russell Caldicott, Interim Executive Director of Finance | 31/05/2024 | | 0 | |
| 319 | PFIG | Internal Audit | Decarbonisation | 2023 | Limited | High | Matter Arising 2: Project Delivery (Design / Operation) | To complete the actions within the specified timeframe, greater focus and scrutiny is required on the action plan. | The Health Board is currently part of the discussions as all actions, timeframes and targets are being reviewed Welsh Government. The Decarbonisation Programme Board do monitor those actions at risk however in the current financial climate all actions will be reviewed and prioritised accordingly to understand what can be implemented and actioned with a realistic timeframe. | Discussion is still ongoing with the Health Board going to tender for the Re-fit programme in January 2024. In addition, this element will be referenced within the development of the plans for IMTP moving forwards in conjunction with the Planning, Transformation and Improvement Directorate. | Russell Caldicott, Interim Executive Director of Finance and Programme Lead | Russell Caldicott, Interim Executive Director of Finance | 31/05/2024 | | 0 | |
| 320 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to establish robust policy, guidance or Standard Operating Procedure to support operational processes. Governance, reporting, and escalation requirements to be clearly defined. | A Putting Things Right (PTR) and Learning Policy will be developed to give clear guidance of operational processes, governance reporting and escalation requirements when learning is identified. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | The draft policy is under development and will be completed by the end of February and submitted for approval. | Matthew Joyes, Deputy Director of Quality | Angela Wood, Executive Director of Nursing and Midwifery | 29/02/2024 | | 0 |
| 321 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident. | Lessons have been learned from the initial implementation of the Once for Wales Datix System whereby handlers of incidents were able to close incidents without completing all mandatory fields – this is being changed forcing completion of the mandatory fields. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure. | Sarah Musgrave, Lead Manager - Learning | Angela Wood, Executive Director of Nursing and Midwifery | 29/02/2024 | | 0 |
| 322 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident. | The ability for incident managers to by-pass steps in the incidents process within the system has also been identified. This issue will be fed back into the national team for development and where this is identified, then education and training will be offered to services/individuals. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure. | Tracey Radcliffe, Head of Patient Safety | Angela Wood, Executive Director of Nursing and Midwifery | 29/02/2024 | | 0 |
| 323 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident. | A regular audit has started and is ongoing providing services with information on where managers are not completing the process. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | Incidents that have been closed in the previous 24 hours are reviewed by the Patient Safety Team to identify any incomplete fields and if required are reopened with feedback back to the incident manager. Evidence to support closure provided - daily/weekly report identifying gaps. Also included is a copy of communication sent to individual responsible for closing, with incident moved back to 'awaiting closure'. | Tracey Radcliffe, Head of Patient Safety | Angela Wood, Executive Director of Nursing and Midwifery | 29/02/2024 | | 0 |
| 324 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to review implemented learning to ensure effectiveness. | The Quality Informatics and Learning Team will work with Clinical Effectiveness Team to explore how learning can be reviewed/audited as part of the learning cycle and feed into the annual audit cycle. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | The work is underway to complete this work with meetings arranged between teams. | Sarah Musgrave, Lead Manager - Learning | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2024 | | 0 |
| 325 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to review implemented learning to ensure effectiveness. | The Organisational Learning Forum was launched earlier this year whose purpose is to identify themes and mechanisms to enable learning to be embedded across the organisation. A new, digital repository of learning and cascade system will be developed. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | The Organisational Learning Forum was launched in 2023. Copy of Organisational Learning Forum minutes from December 2023 provided as additional evidence for closure. | Chris Lynes, Deputy Executive Director of Nursing | Angela Wood, Executive Director of Nursing and Midwifery | Completed | | 0 |
| 326 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 1: Lessons Learnt (Design) | Management to review implemented learning to ensure effectiveness. | A new, digital repository of learning and cascade system will be developed. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | The work is underway to complete this work. A developer has been assigned to this work and several workshops with clinical and corporate staff have been held to establish the project. | Sarah Musgrave, Lead Manager - Learning | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2024 | | 0 |
| 327 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 2: Make it Safe (Plus) (Design) | Management to formally document and communicate the principles and requirements of Make it Safe (Plus) to ensure consistency across the Health Board. Governance, reporting, and escalation requirements to be clearly defined. | A full review of the incident process and procedure has been commenced, which will be co-designed with staff to ensure that the new procedure is fit for purpose and workable for staff undertaking rapid reviews/investigations and learning. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | The Patient Safety Team (PST) have conducted a scoping and engagement exercise across all the Integrated Health Communities (IHC) and Divisions to establish 'local priorities' along with current practices and processes in place, and to establish good practice which can be shared and utilised across the Health Board. In addition, identification of areas which require attention and/or improvement, including where there is a requirement to avoid duplication and where variation is a factor were determined. The outcomes of these engagement events were summarised into a proposal for the Health Board Patient Safety Group with an ask to review and feedback any additional thoughts or comments to finalise the paper for governance. | Tracey Radcliffe, Head of Patient Safety | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2024 | | 0 |
| 328 | QSE | Internal Audit | Lessons Learnt | 2023 | Limited | High | Matter Arising 2: Make it Safe (Plus) (Design) | Management to ensure all Make it Safe (Plus) reviews are documented and recorded appropriately i.e. though regular audit / review. | The Patient Safety Team (PST) review and report on completion of MIS Plus and timescales. This information is shared with services. The PST will undertake a weekly audit/review to provide assurance that reviews are documented and recorded appropriately. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | Following initial audits in August 2023, monthly audits continue with incidents without the MIS+ completed identified and reported back to Governance Leads and Programme Lead. | Tracey Radcliffe, Head of Patient Safety | Angela Wood, Executive Director of Nursing and Midwifery | 31/03/2024 | | 0 |

| | | | | | | | | | | | | | | | |
|-----|-----|----------------|--|------|------------|------|--|---|--|---|--|--|--|------------|---|
| 329 | QSE | Internal Audit | Adult and Older Persons Mental Health Unit | 2023 | Reasonable | High | Matter Arising 4: Electrical Infrastructure (Design / Operation) | <p>At future projects</p> <p>The UHB should seek to understand how this issue was only identified as a serious risk at a late stage. This learning should be applied to all future schemes the UHB undertake to ensure that issues such as this do not have the potential to derail future projects.</p> | <p>It was documented within the Estates Annex that was submitted for the OBC that the Health Board were arranging a separate project to increase electrical capacity. At the time this was only minimally increased due to availability within the network and did not increase to the extent required. Net zero targets have also had a major impact on the scheme. A Meeting is arranged with WG to discuss the option of a separate business case submission to resolve Electrical Infrastructure.</p> <p>The Health Board have reviewed learning that can be applied to future schemes. At key project stages, service infrastructure will be reviewed in relation to the project and the site development control plan.</p> <p>Key drivers will be:</p> <ol style="list-style-type: none"> 1) To update existing Development Control Plans to align to Estates Strategy. 2) To fully understand and monitor site services infrastructure in terms of capacity and compliance for each site. | Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee | WG have supported fee to develop business case for the YGC electrical infrastructure upgrade. Detailed design ongoing. Project core team and project board commenced. The BC is due for submission to WG in September 2024, ensuring electrical capacity is aligned to the AOPMH scheme. The update DCP will be updated as part of the work stream. Evidence of lessons learnt on other capital projects, examples being, Llandudno Orthopaedics and Wrexham Continuity. | Daniel Eyre Head of Capital Development | Teresa Owen, Health Board Lead For MHL and Welsh Language | 27/11/2023 | 0 |
|-----|-----|----------------|--|------|------------|------|--|---|--|---|--|--|--|------------|---|

AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE AT MARCH 2024 AUDIT COMMITTEE

Key:

| |
|----------------------|
| Limited assurance |
| Reasonable assurance |
| n/a assurance |

| DIRECTOR OF CORPORATE GOVERNANCE | | | |
|----------------------------------|-----|---|--|
| 1 | 114 | Standards of Business Conduct: Declarations | Declarations of Interest Compliance |
| 2 | 115 | | Declarations of Interest Compliance |
| 3 | 116 | | Declarations of Interest System |
| 4 | 117 | | Gifts and Hospitality requirements |
| 5 | 118 | | Monitoring and Reporting arrangements |
| 6 | 183 | Board and committee reporting | Request and submission of papers and reports |
| 7 | 185 | | Reporting Breaches |
| 8 | 186 | | Cycles of Business and Terms of Reference. |
| 9 | 187 | Chairs action | Process Design |
| 10 | 188 | | Standard Operating Procedure |
| 11 | 244 | Structured Assessment 2019 | R1 |
| 12 | 254 | Risk Management and Board Assurance Framework | Oversight and scrutiny of Divisions / IHCs |

| EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY | | | |
|---|-----|---------------------------------------|---|
| 1 | 57 | Quality Improvement Strategy | Reporting progress of Quality Improvement Strategy (QIS) |
| 2 | 258 | Data analysis – Triangulation of data | Triangulation of Data sets using consistent naming conventions |
| 3 | 260 | | Quality, Safety and Experience Committee reporting |
| 4 | 290 | Falls Management | Policy (Design) |
| 5 | 291 | | Policy (Design) |
| 6 | 292 | | Policy (Design) |
| 7 | 294 | | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) |
| 8 | 295 | | All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation) |
| 9 | 301 | | Training (Operation and Design) |
| 10 | 303 | | Governance (Operation) |
| 11 | 306 | | Governance (Operation) |
| 12 | 321 | Lessons Learnt | Matter Arising 1: Lessons Learnt (Design) |
| 13 | 322 | | Matter Arising 1: Lessons Learnt (Design) |
| 14 | 323 | | Matter Arising 1: Lessons Learnt (Design) |
| 15 | 325 | | Matter Arising 1: Lessons Learnt (Design) |

| HB LEAD FOR MHLD AND WELSH LANGUAGE | | | |
|-------------------------------------|-----|---|--|
| 1 | 169 | Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website | Policy and Management of Website Information |
| 2 | 273 | Hergest Unit Notice of Contravention (NoC) Action Plan | Action Plan evidence |

EXECUTIVE DIRECTOR OF OPERATIONS

| | | | |
|----|-----|---|---|
| 1 | 172 | Effective Governance: YWM | Finance |
| 2 | 175 | | Risk Management |
| 3 | 178 | Effective Governance: YG | Clinical audit |
| 4 | 216 | USC: Urgent Primary Care Centres - Business case outcomes | Governance Frameworks and Communication Strategies |
| 5 | 218 | achieved | Benefits Realisation |
| 6 | 235 | Review of Eye Care Services | R2 |
| 7 | 240 | | R7 |
| 8 | 256 | Planned Care Recovery and Transformation Group | Planned Care Recovery and Transformation Group |
| 9 | 284 | GP Out of Hours | Process Management (1.1) |
| 10 | 285 | | Process Management (1.2) |
| 11 | 287 | | Progress Update Log |
| 12 | 308 | Waiting List Management: Review of the WG initiated Patient | WG initiated, locally delivered tranche 'patient' validation exercise - (Operation) |
| 13 | 309 | Validation Exercise, Risk Stratification and patient removal from | WG initiated, locally delivered tranche 'patient' validation exercise - (Operation) |
| 14 | 310 | lists | WG initiated, locally delivered tranche 'patient' validation exercise - (Operation) |
| 15 | 311 | | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) |
| 16 | 312 | | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) |
| 17 | 314 | | Matter Arising 2 - Assessment of clinical risks relating to delays (Operation) |
| 18 | 315 | | Matter Arising 3 - Patients removed from waiting lists (Operation) |
| 19 | 316 | | Matter Arising 3 - Patients removed from waiting lists (Operation) |

INTERIM EXECUTIVE DIRECTOR OF FINANCE

| | | | |
|---|-----|--|---|
| 1 | 268 | Performance Management – Quality and Performance Reporting and Accountability Arrangements | Accountability meetings (a) |
| 2 | 318 | Decarbonisation | Matter Arising 1: Governance Structure (Design), Monitoring & Reporting (Operation) |

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|--|---|---|--|--|
| Teitl adroddiad: <i>Report title:</i> | Special Measures Update | | | |
| Adrodd i: <i>Report to:</i> | Audit Committee | | | |
| Dyddiad y Cyfarfod: <i>Date of Meeting:</i> | 7 th May 2024 | | | |
| Crynodeb Gweithredol: <i>Executive Summary:</i> | The purpose of this paper is to provide a brief update on Special Measures, including progress regarding Independent Reviews, as reporting arrangements transition into the Annual Delivery Plan. | | | |
| Argymhellion: <i>Recommendations:</i> | The Committee is asked to NOTE the Special Measures update and its transition into the Annual Delivery Plan, in terms of reporting, and the latest update regarding Independent Reviews. | | | |
| Arweinydd Gweithredol: <i>Executive Lead:</i> | Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive) | | | |
| Awdur yr Adroddiad: <i>Report Author:</i> | Geraint Parry, Special Measures Programme | | | |
| Pwrpas yr adroddiad: <i>Purpose of report:</i> | I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/> | I Benderfynu arno <i>For Decision</i> <input type="checkbox"/> | Am sicrwydd <i>For Assurance</i> <input type="checkbox"/> | |
| Lefel sicrwydd: <i>Assurance level:</i> | Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i> |
| <p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></p> | | | | |
| Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i> | To support Special Measures | | | |
| Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i> | Not applicable | | | |

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|---|----------------|
| <p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p> | Not applicable |
| <p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p> | Not applicable |
| <p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p> | Not applicable |
| <p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p> | Not applicable |
| <p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p> | Not applicable |
| <p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p> | Not applicable |
| <p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p> | Not applicable |
| <p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p> | Not applicable |
| <p>Camau Nesaf: Gweithredu argymhellion</p> <p>Next Steps: Implementation of recommendations</p> | |

Special Measures Update

1) Introduction

This report presents a brief overview of Special Measures related activity as the Health Board transitions from the initial Stabilisation Phase and begins to develop longer-term plans. The paper describes how the Special Measures response plan has transitioned into the Annual Planning Cycle as part of the development of the 3-year plan for the Health Board.

The paper also provides a summary position against the Independent Reviews commissioned by Welsh Government as we look to conclude the discovery phase of our work, and move into the design of new solutions.

2) Annual Delivery Plan

During the Special Measures Stabilisation Phase, 90-day planning cycles have provided pace and traction to support early progress. As the organisation begins to stabilise and prepare for the next phase in our improvement journey, there is a requirement to couple this approach with a focus on developing plans more than 90 days at a time in order to ensure that we are addressing the root cause of our issues.

This will enable the organisation to place a focus on issues that require a more transformational approach and will not be resolved in short time frames, and ultimately lead to building an effective organisation for the long term.

As outlined previously to the Board, the five Special Measures Outcomes have evolved to become five strategic objectives for the organisation as part of the 3-year plan. The Special Measures response plan will be therefore become integrated with the resulting Annual Delivery Plan and monitoring of progress against Special Measures priorities will be undertaken as part of Annual Plan monitoring.

The primary oversight of the Annual Delivery Plan on behalf of the Board will be via the Planning, Population Health, and Partnerships (PPHP) committee, who will receive progress reports against all areas of the plan. This committee will work in close partnership with Performance, Finance and Information Governance (PFIG) committee regarding financial and performance aspects in relation to plan delivery.

The overarching approach to executing successful delivery of the plan will be to develop a strong thread through the 3-year plan, the Annual Delivery Plan, Directorate Plans, and then subsequently into Team and Individual objectives. This will ensure a strong link between the objectives across the organisation with the overarching strategy of the organisation. The detail within the Annual Delivery Plan is being finalised during April and being socialised within the organisation.

Monthly highlight reports will be developed and shared across relevant committees to cover the whole of the Annual Delivery Plan, with the Special Measures related milestones identifiable within the overall plan. If required the officers responsible for individual areas of the plan would be able to attend committee to present a more detailed update to supplement the update reports from the Organisational Portfolio Office.

3) Independent Reviews

As outlined in previous reports, each of the Independent Reviews has been mapped to an appropriate committee of the Board for oversight, and presentations have been received from report authors. These were then supplemented by a management response, before publication into the public domain via the full Board meeting. It is worthy of note that the Executive Portfolio review did not follow this route following agreement that this should result in a set of proposals from the CEO, and the Quality Governance review is also operating in a more continuous manner and is yet to generate a report.

The Audit committee has retained oversight of the overall arrangements and the following table provides a summary of the current position.

| Independent Review | Current Status | Progress Update |
|---|---|---|
| Review of the Office of the Board Secretary | These 4 reports were published at the November Board and Action Plans are progressing | Following publication of the reports, the delivery of the agreed recommendations have been progressing with an update provided to March Board. Further tracking underway and will be reported to May Board. |
| Patient Safety Review | | |
| Review of the usage of Interims | | |
| Mental Health Inpatient Safety Units | | |
| Executive Portfolio Review | Report received, and Health Board Chair requested that the CEO develop structure proposals in response. | The CEO developed a set of proposals for the structure of the Executive Team which were approved. A number of posts are now out to advert and appointments expected by the end of Q1. |
| Vascular | Part 1 presented to QSE in December. Part 2 now received and Management Response due to QSE in June. | The report author attended a development session of QSE in December and an initial action plan was developed following receipt of part 1. The report on part 2, which was a case note review, was received in early April, and the action plan will be augmented, and a management response submitted to QSE in June. |
| Contract Procurement | Reviewer presented to PFIG Development session in March. Management response due at April PFIG. | A management response will be submitted to PFIG on the 30 th April, and a number of actions are already progressing. |
| Review of Planning | Reviewer presented to PFIG Development session in March. Management response due at April PFIG. | The review was received during March, and the management response will be submitted to PFIG on the 30 th April. A series of debrief sessions for the planning cycle are underway as part of the response plan. |

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| Mental Health Review of Reviews | Review received. Scheduled for presentation at the May Board meeting. | This review requires some careful co-ordination and engagement with a number of families to ensure sensitivities with historic issues are recognised. The Engagement team are leading on this approach which needs to conclude before the report can be published. This is currently scheduled to be received in private session at the May Board meeting. |
| Quality Governance Review | Review underway. | This review differs in approach and is a collaborative piece of work with the NHS Executive as opposed to a discrete review which results in a report. The NHS E will be working alongside the Health Board developing longer term plans, and currently meet fortnightly with key senior individuals. The end point for the work has not been agreed at this stage, however it is envisaged that an interim report will be produced later in the year, and a final report when the work concludes. |

4) Summary and Recommendations

Overall, good progress has been made in relation to the Independent Reviews with the majority of the discovery work having now concluded. Whilst receipt by the Health Board of some of the reports was delayed, the management responses have been mobilised as soon as received. Following key meetings over the next few weeks 9 out of the 10 reviews will have been presented to Board committees ahead of publication.

The ongoing Quality Governance Review will remain the final piece of work yet to conclude.

The Committee is asked to **NOTE** the Special Measures update and its transition into the Annual Delivery Plan, in terms of reporting, and the latest update regarding Independent Reviews.

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|---|--|
| Teitl adroddiad: <i>Report title:</i> | Board Assurance Framework and Corporate Risk Register |
| Adrodd i: <i>Report to:</i> | Audit Committee |
| Dyddiad y Cyfarfod: <i>Date of Meeting:</i> | Tuesday, 07 May 2024 |
| Crynodeb Gweithredol: <i>Executive Summary:</i> | <p>1. The purpose of this standing agenda item is to provide a Chair's assurance summary from Risk Management Group and an update position of the Corporate Risk Register and Board Assurance Framework risks.</p> <ul style="list-style-type: none"> • Risk Management Chair's Assurance Report: The Risk Management Group (RMG) meeting on 9th April 2024 reviewed the Board Assurance Framework (BAF), Corporate Risk Register (CRR), divisional risk registers, and emerging risks. • Appendix 1- Risk Management Dashboards: Corporate Risk Register & Board Assurance Framework • Appendix 2- 2 Board Assurance Framework risks • Appendix 3- Full Corporate Risk Register <p>Key changes to note <i>(approved by the Risk Management Group and Executive Team on 10 April 2024):</i></p> <p>Board Assurance Framework changes:</p> <ul style="list-style-type: none"> • Estates risk report based on the Annual Plan Deliverables, with a score of 20. • Leadership risk (aligned to Annual Plan Deliverables) reduction from 16 to 12 (based on achieving the milestones within the annual plan and noting the corporate risk CRR24-16 Leadership, which is a broader perspective of HB risks, to remain at a score of 16). <p>Corporate Risk Register changes:</p> <ul style="list-style-type: none"> • Safeguarding corporate risk reduced from 16 to 12; but to remain on the corporate risk register for monitoring. |
| Argymhellion: <i>Recommendations:</i> | <p>The Committee is asked to note and receive assurance for:</p> <ul style="list-style-type: none"> • Chair's Assurance Report from the Risk Management Group • Board Assurance Framework • Corporate Risk Register. <p>Endorse changes highlighted around the Board Assurance Framework and realigning this to the Objectives of the Health Board, recently approved at the March Board.</p> |

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| Arweinydd Gweithredol: <i>Executive Lead:</i> | Pam Wenger, Director of Corporate Governance | | | |
| Awdur yr Adroddiad: <i>Report Author:</i> | Nesta Collingridge, Head of Risk Management | | | |
| Pwrpas yr adroddiad: <i>Purpose of report:</i> | I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/> | I Benderfynu arno <i>For Decision</i> <input type="checkbox"/> | Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/> | |
| Lefel sicrwydd: <i>Assurance level:</i> | Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i> |
| Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:N/A</i> | | | | |
| Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i> | Links to the BAF detailed in respective CRR reports | | | |
| Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i> | It is essential that the Health 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? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i> | N/A | | | |
| Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i> | N/A | | | |
| Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) | Links to the BAF detailed in respective CRR reports | | | |

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| <p>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</p> | |
| <p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p>Financial implications as a result of implementing the recommendations</p> | <p>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.</p> |
| <p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p>Workforce implications as a result of implementing the recommendations</p> | <p>N/A</p> |
| <p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p>Feedback, response, and follow up summary following consultation</p> | <p>Risks approved by Executives as the lead for the risk, Risk Management Group 09/04/24 Executive Team on the 10/02/24, P&C 11/04/24, QSE 18/04/24, PPHP 23/04/24 and PFIG 30/04/2024. (paper produced prior to PFIG discussion)</p> |
| <p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p> | <p>BAF paper which further links Tier 1 and CRR.</p> |
| <p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p> | <p>N/A</p> |
| <p>Camau Nesaf:</p> <p>Next Steps:</p> <ol style="list-style-type: none"> 1. Endorsement from Audit Committee on closure of the 23/24 BAF 2. Endorsement from Audit Committee on the next stages of the development of the BAF realigning this to the 5 strategic objectives 3. Risk Management workshop for the Board members identifying BAF risks | |
| <p>Rhestr o Atodiadau:</p> <p>List of Appendices:</p> <ol style="list-style-type: none"> 1. Appendix 1 – BAF and CRR Dashboard 2. Appendix 2- 2 BAF Risks 3. Appendix 3- Full Corporate Risk register | |

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

1. Purpose

The purpose of this report is to provide Audit Committee with information and assurance of the management of the significant risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) as well as assurance from the Risk Management Group.

This paper provides risk updates from:

The Board Assurance Framework

The Corporate Risk Register

Chair's Assurance Report from the Risk Management Group

Appendix 1: Risk Dashboards and Risk Management Commentary

Appendix 2: contains detailed information from both risk registers, including controls/mitigations and action plans to address the risk. (5 Board Assurance Framework Risks /17 Corporate Risks (1 private)).

2. Changes to note

The dashboards for each respective risk register highlight changes to two BAF scores and the 1 corporate risks.

- SP14 – Estates and Capital- increased to 20
- SP16- Board Leadership & Governance decreased from 16 to 12
- CRR24-03: Safeguarding – Current score reduced from 16 to 12 and recommended that the risk remains on the corporate risk register for monitoring.
- Feedback from Committees noted in the dashboard where applicable.

Also proposals for the 24/25 BAF within the risk update for the BAF.

3. Risk Updates from Board Assurance Framework

Table 1 highlights

One BAF risk has been approved by the Executive Team for being moderated down:

SP16- Board leadership and governance - Leadership BAF was approved for reduction at Executive Team and People & Culture Committee however this is due to the defined scope of the deliverables in the Annual Plan around independent member recruitment and induction etc. and the Corporate Risk around Leadership CRR24-16 risk remains at a score of 16 and was recommended at Risk Management Group to be strengthened to include the recruitment of the Executive Team and broadened beyond the scope of the Board.

Furthermore, Audit Committee is asked to endorse the closure of the 23/24 BAF noting that the Board will receive an Annual Delivery Plan and therefore the Board Assurance Framework will need to be re-framed to be aligned to the Three Year Plan, and in undertaking this review, agreement on the frequency of reporting will need to be determined.

The Health Board has set out a 2024-2027 Three Year Plan, focused around five key strategic objectives:

1. Building an effective organisation
2. Developing strategy and long-lasting change
3. Creating compassionate culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Establishing an effective environment for learning

To ensure successful delivery of these objectives and achievement of BCUHB's overall vision, it is critical that the organisation has a robust Board Assurance Framework (BAF) in place. The BAF provides a structured approach for the Board to identify, assess and manage the principal risks that could threaten the attainment of the Health Board's strategic goals.

This paper outlines the approach for developing the BAF in alignment with BCUHB's five strategic objectives. The Audit Committee is asked to review and comment on this approach ahead of the May Board meeting.

Key steps will include:

| | |
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| Review the current framework to align to the Objectives | May - June |
| Agree set of principal risks against the Objectives | May - June |
| Plan session with the Board on Risk Management to agree set of principle risks and review of risk appetite | July |

Reporting

The development of board assurance arrangements should be a logical extension of the Corporate Risk Register. The Board Assurance Framework should relate directly to the organisation strategy and are identified 'top-down' by the Executive Team and approved by the Board. The BAF has a different function to the corporate risk register, which consists of the high-operational risks.

The current reporting of the Board Assurance Framework is at every meeting of the Board and Committees. It is proposed that the frequency of the reporting of the Board Assurance Framework should be changed from bi-monthly to twice a year. The rationale for this is that the BAF should be comprised of strategic risks, which should relate directly to the achievement of the organisation's strategy (recognising that there is currently no organisation strategy for BCUHB).

Once the Board has reviewed the previous annual plan non-deliverables and risks and newly identified risks (no more than 10 BAF risks), we will look to agree clear ownership and monitoring arrangements for each risk in line with the Risk Management Framework.

Identified responsible Executives will be asked to work in articulating the risk, assessing the potential impact and likelihood of each risk, mapping out the key controls and SMART mitigating actions in place to manage the risks, identifying gaps in controls or assurance. Risk reports are to be submitted to the Executive Team for approval, and assign overall accountable committees in preparation to and presentation back to the committees and Board in September 2024.

Integrating the BAF with the organisation's risk management processes will be key and designated Executive representatives will be asked to commit to providing the Planning and

Corporate Risk Management Team will bi-monthly updates prior to individual Executive sign off and Executive Team meeting approval, quarterly submission committees and Board of the as per the Risk Management.

Development of the 2024-2027 BAF will be an iterative process, requiring input and ownership from the Board and senior leaders. Regular review of the three year plan deliverables and subsequent risks BAF will enable the Board to maintain effective oversight of the organisation's risk profile and ensure timely action is taken to manage risks to delivery of the strategic objectives. The relationship between corporate risks will be articulated to committees and the relationship between corporate risks, operational risks will be articulated to individual executives and Risk Management Group as per the Risk Management Framework.

By aligning the BAF to BCUHB's strategic objectives, the Health Board will have a clear line of sight between risks, mitigations and the achievement of its vision for the population of North Wales. The Audit Committee will play a key role in providing assurance to the Board on the effectiveness of the BAF and the wider control environment.

DEVELOPMENT PROCESS OF BOARD ASSURANCE FRAMEWORK



Our Purpose

To improve health and deliver excellent care



Our Values

Put patients first
Work together
Value and respect each other
Learn and innovate
Communicate openly and honestly



24-27 Strategic Objectives

Objective 1: Building an effective organisation
Objective 2: Developing strategy and long-lasting change
Objective 3: Creating compassionate culture, leadership and engagement
Objective 4: Improving quality, outcomes and experience
Objective 5: Establishing an effective environment for learning



Review of Annual Plan Deliverables & Identifying BAF Risks

Engaging with the Board and Executive Team to identify the most significant risks to delivery of each strategic objective.



Ongoing Management and Monitoring

Assurance to Committees and Board

4. Risk Updates from Corporate Risk Register

There are 17 consolidated Corporate Risks. The full details of these risks are highlighted in Appendix 2 and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

1) Key Highlights

The Corporate Risks Dashboard highlights the current score, target score in relation to the risk appetite. One risk has a reduced score following update and review by the services:

- CRR24-03: Safeguarding – Current score reduced from 16 to 12 and recommended that the risk remains for monitoring on the corporate risk register. See risk report for full rationale in reduction of likelihood from 4 to 3.

To note, CRR24-05: 2023/24 Financial Plan - Reduction in current risk score from 20 to 16 – Rationale : Year to date deficit above plan significantly reduced. Change in risk score **not approved** - and feedback provided around realigning this to the 24/25 Financial Plans.

Many of the risks are newly developed and therefore currently retain their initial risk scores and have a longer term outlook target date (2 year+).

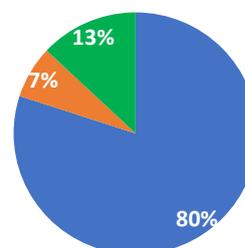
Out of the 17 corporate risks, 105 actions have been developed to mitigate the risks. 13 actions have been completed, 80 actions are progressing and on track and 7 actions are overdue.

The 7 overdue actions span across 7 different corporate risks, with the ICT Failure and Cyber risk (CRR24-17) and the Planned Care risk (CRR24-11) each having 3 overdue actions.

However positive assurances include 80% of actions being on track and the reduction of one score in line with target date.

ACTION STATUS OF CORPORATE RISKS

■ Progressing ■ Overdue ■ Completed



5. Summary of Risk Management Group meeting on 9th April 2024

The Risk Management Group (RMG) meeting on 9th April 2024 reviewed the Board Assurance Framework (BAF), Corporate Risk Register (CRR), divisional risk registers, and emerging risks.

Board Assurance Framework:

Out of 19 strategic priorities, 5 remain as a high risk of non-delivery. Board Assurance Framework risks will be aligned to Health Board objectives now that the objectives have been approved at the last Board Meeting. Board Assurance Framework risk changes approved were Estates, with a score of 20, and Leadership reduction to 12 (based on the milestones within the annual plan and corporate risk CRR24-16 Leadership which is broader, to remain at a score of 16).

Corporate Risk Register:

Four risks were proposed for a reduction in score. Recommendations for reduction were approved for the Safeguarding risk. Finance proposed a reduction in score from 20 to 16 however recommendations were made around strengthening the Financial Corporate Risk to 24/25 Plans and the risk of a potential deficit.

People & Wellbeing, and Leadership/Special Measures risks were proposed to reduce both scores from 16 to 12 by the Directorate however due to the lack of a fully recruited Executive team and increasing staffing operational risks (21 risks reported within the last two months) it was proposed the scores remained at 16. *Further presented and discussed at People & Culture Committee.*

Risks for Escalation/De-Escalation:

The overview of high operational risks was noted, particularly the increase in staffing risks (21) and closure of 34 high risks. A risk escalated related to a backlog of patient paper case notes will be managed under an existing corporate risk, 'Availability and Integrity of Information'. The business case for managing the backlog was not approved, meaning the continued issue of duplicate patient numbers could pose a patient safety risk. Furthermore, a risk and issue related to the preparedness for a potential outbreak, such as measles, were raised, including shortages of post-exposure prophylaxis and lack of robust outbreak plans. An action was agreed to escalate this risk through the appropriate channels, through the responsible Executive.

Executive Team Meeting:

The group received an update from the Executive Team Meeting, plans for future meetings include risk sprints to review corporate risks and discuss developments such as strategic training for Executives. The function of the Risk Management Group will be discussed with the Executive Team before confirming the Terms of Reference which were noted as overdue for review.

Divisional Risk Reports:

The group received Divisional Risk Register Reports as per the cycle of business in relation to: Primary Care, Health & Safety, Women's Services, Mental Health & Learning Difficulties, Cancer Services, and Diagnostic & Specialist Clinical Support presented their risk registers. Key risks included health and safety prosecutions, ligature risks, medical workforce, and treatment time risks. Actions were agreed to support divisions in managing and documenting their risks effectively, including monitoring review dates (Primary Care) and meeting quoracy (Mental Health & Learning Difficulties Division).

Appendix 1 - BAF and CRR Risk scoring and progress

TABLE 1 – BAF Dashboard

| Title | Score | Revision | Annual Plan Analysis | Risk Management Commentary |
|---|-------|---|---|---|
| Changes to note | | | | |
| Strategic Priority P14 Estates and Capital | 20 |  | Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 7 actions completed, 7 Amber, 0 Red. | Risk developed by service and approved by Executive RMG 09/04/24 and ET 10/04/24. |
| Strategic Priority P16 Board leadership and governance | 12 |  | Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q4 (23/24). 8 actions completed, 2 Amber, 0 Red. | Risk score moderated down from 16 to 12 as most actions completed. |
| No changes this reporting cycle | | | | |
| Strategic Priority P2 Primary Care | 9 | TBC | Overall 'Amber' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1 (24/25) and 1 priority delayed from Q4 to Q1 (24/25). 0 actions completed, 2 Amber, 2 Red. | Risk score being monitored. |
| Strategic Priority P3 Planned Care | 9 |  | Overall 'Green' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25). 1 action completed, 0 Amber, 0 Red. | Risk score being monitored |
| Strategic Priority P5 Cancer | 20 |  | Overall 'Amber' Delivery Confidence With 1 priority delayed from Q3 to Q1 (24/25). 3 actions completed, 2 Amber, 0 Red. | Delivery Confidence to be monitored, risk has been updated remains at 20. |
| Strategic Priority P4 Urgent and Emergency Care | 0 |  | Overall 'Green' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1/Q4 (23/24). 2 actions completed, 0 Amber, 0 Red. | - |
| Strategic Priority P10 Children | 20 |  | Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q3 (24/25). 0 actions completed, 0 Amber, 0 Red. | Score to potentially be moderated down if confidence is positive. |
| Strategic Priority P11 Wider Delivery | TBC | TBC | Overall 'Amber' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red. | Assessment of the risk score being reviewed for being completed |
| Strategic Priority P12 Workforce | 12 |  | Overall 'Green' Delivery Confidence With all on track. 4 actions completed, 0 Amber, 0 Red. | Risk score to potentially be further moderated down if confidence is positive. |

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| Strategic Priority P13 Digital, Data and Technology | 20 | -  | Overall 'Amber' Delivery Confidence With multiple priorities having red or amber delivery confidence. 5 actions completed, 4 Amber, 3 Red. | Risk has been updated remains at 20. |
| Strategic Priority P15 Partnerships | 9 | - | Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 9 actions completed, 3 Amber, 0 Red. | To remain as a low risk as several actions completed. |
| Strategic Priority P17 Organisational development | 12 | TBC | Overall 'Amber' Delivery Confidence With 1 priority delayed from Q4 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red. | Risk score should be reviewed and possibly may increase. |
| Strategic Priority P18 Quality, Innovation and Improvement | 20 |  | Overall 'Green' Delivery Confidence with 1 action delayed from Q3 to Q4 (23/24). 0 actions completed, 0 amber, 0 red. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed." | Risk score has subsequently been reduced from 25 to 20 . Reconsider impact of 5 in following iteration of report and provide rationale if remains. Change approved by Executive Team 14/02/24 and Endorsed at QSE 20/02/24 |

Table 2 – Corporate Risk Register Dashboard

| Lead | Ref | Risk Title | Current Score (Likelihood x Impact) | Risk Target Score | Appetite Main Risk Type | Lead Board Committee | Risk Management Commentary |
|------|----------|-------------------------------|--|-------------------|---------------------------|----------------------|--|
| | | | | | Appetite Level | | |
| EDoW | CRR24-01 | People, Culture and Wellbeing | 3 x 4 = 16 ↔ | 8 | People 4 - Seek | P&C | New risk as of Dec 23. 11 actions identified, 5 completed, 2 progressing, 1 overdue and 3 new actions . This risk is presented to the RMG and Executive Team in April for a proposed reduction in score as a result of completed actions the likelihood as reduced from a 4 to a 3, reducing the score from 16 to 12. Proposal rejected at Risk Management Group (09/04/2024) and Executive team (10/04/2024), score to remain as 16. To be further strengthened considering the recent increase in staffing T1 risks reported. |
| EDoN | CRR24-02 | Patient Safety-Falls | 5 x 4 = 20 ↔ | 12 | Quality 3 - Open | QSE | Escalated from operational risk as of Dec 23. 6 actions identified, 1 completed, 5 progressing. Some action dates amended from the 31/03/2024 to the 30/04/2024. Actions are on track for the April 2024 target date. However, the inherent and current risk scores are both 20, the existing controls have not reduced the risk yet. Target date likely to change as this risk is broadened from being operational and just around falls to being strategic and more generally patient safety focused. Work ongoing by the service to further develop the risk with the inclusion of additional patient safety risks i.e. healthcare acquired pressure ulcers, deterioration of patients etc. QSE 18/04/24 feedback-To be managed operationally and 'Patient Harm' strategic risk opened. |
| EDoN | CRR24-03 | Safeguarding | 4 x 3 = 12 ↓ | 8 | Quality 3 - Open | QSE | This risk is presented to the Risk Management Group and Executive Team in April for a proposed reduction in score but to remain as reported on CRR. See rationale within corporate risk of reduction in risk of public scrutiny due to National dependencies. QSE 18/04/24 score change endorsed. |
| EDoN | CRR24-04 | Failure to Embed Learning | 4 x 5 = 20 ↔ | 5 | Reputational 4 - Seek | QSE | New CR as of Dec 23, 7 actions identified, 0 completed but all progressing. The initial March 2024 Highlighted to QSE-action deadlines have all been extended to April-June 2024. The current risk score remains at 20. Some actions delayed due to reliance on NHS Executive National team. |
| EDoF | CRR24-05 | Financial Sustainability | 5 x 4 = 20 ↔ | 12 | Financial 2 – Cautious | PFIG | Risk score has remained at 20 since opened in March 2023. 2 actions identified and progressing. This risk is presented to the Risk Management Group and Executive Team in April for a proposed reduction in score from 20 to 16 as the year-to-date deficit has improved, reducing the likelihood reduced from 5 down to 4. Proposal |

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| | | | | | | | rejected at Risk Management Group (09/04/2024) and Executive team (10/04/2024), score to remain as 16. To be further strengthened to the 24/25 risk of possible deficit. |
| EDoF | CRR24-06 | Suitability and Safety of Sites | 4 x 4 = 16 ↔ | 8 | Quality 3 – Open | PFIG | Newly developed strategic risk March 24, 7 actions identified, 0 completed, 6 progressing, 1 overdue . The overdue action relates to develop a Business Case Review Group. More progress is needed on the 6-facet survey, rationalisation programme and discretionary capital spend to reduce the risk in line with the 2026 target date. The backlog maintenance costs are £348m . |
| CDIO | CRR24-07 | Availability and Integrity of Patient Information | 5 x 4 = 20 ↔ | 12 | Quality 3 - Open | PPPH | Newly developed strategic risk Dec 23, 6 actions identified, 0 completed, 6 progressing. The inherent and current risk scores are both high at 20, indicating the existing controls are not adequate to control the risk. Resource requirements and system integration remain a concern to address this risk. PPHP 23/04/24 to address overdue actions prior to AC and Board. |
| EDoPH | CRR24-08 | Population Health | 5 x 4 = 20 ↔ | 12 | Reputational 4 - Seek | PPPH | Redrafted to be more strategic Nov 2023, No change in score , 9 actions identified, 0 completed, 9 progressing. 2026 target date. However, the inherent and current risk scores are both 20 , so the controls are not reducing the risk. Issues remain around securing long-term funding, partner abilities to prioritise population health, and the wider determinants of health. PPHP 23/04/24 Short term SMART actions required. |
| EDoO | CRR24-09 | Community Care and Primary Provision | 4 x 5 = 20 ↔ | 12 | Quality 3 - Open | QSE | Newly developed strategic risk Feb 24, 5 actions identified, 1 completed, 4 progressing. Actions are on track for the 2025 target date. However, the inherent and current risk scores are both 20 , indicating the controls are not yet reducing the risk. Timely development of a Primary Care strategy and governance model is key to reducing this risk, along with resourcing plans to address workforce and capacity gaps to reduce the likelihood of 5 . QSE 18/04/24 -risk two be split into two. |
| EDoO | CRR24-10 | Urgent and Emergency Care | 4 x 5 = 20 ↔ | 12 | Quality 3 - Open | PFIG | Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 6 progressing. Actions due August 2025. Challenges remain around ambulance handover delays, hospital flow, alternative pathways, and community capacity to mitigate this risk further which is further detailed in the performance reports to Board. |
| EDoO | CRR24-11 | | 5 x 4 = 20 ↔ | 1 | Quality | PFIG | Newly developed strategic risk Feb 24, 5 actions identified, 0 completed, 2 progressing, 3 overdue. Highlighted to PFIG- 3 overdue actions around recruitment, funding approval and leadership require immediate resolution to |

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|-------|----------|---|-----------------|----|--------------------------|------|--|
| | | Planned Care | | | 3 - Open | | address this risk impacting several specialities. Work remains to put sustainable plans in place to tackle the backlogs and avoid patient harm which is further rationalised within the details of the performance reports to Board. |
| EDoO | CRR24-12 | Areas of Clinical Concern (encompasses ophthalmology and dermatology) | 5 x 3 = 15 ↔ | 12 | Quality 3 - Open | QSE | Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 6 progressing. The lack of substantive medical leads and reliance on locum staffing for several fragile services is impeding progress. Focused leadership and clinical pathway work is needed to mitigate this risk. |
| EDoTH | CRR24-13 | Timely Diagnostics | 4 x 5 = 20 ↔ | 5 | Reputational 4 - Seek | QSE | Newly developed strategic risk Feb 24, 5 actions identified, 0 completed, 5 progressing. All actions are on track against the 2025 target date. Challenges remain around radiology staffing, ageing IT infrastructure and acting on test results and development of a Diagnostic Strategy and workforce plan required to reduce risk impact of 5. |
| EDoTH | CRR24-14 | Harm from the Medical Devices/Equipment | 4 x 4 = 16 ↔ | 8 | Quality 3 - Open | QSE | Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 5 progressing, 1 overdue . The overdue action around internal communication requires focus. More progress is needed on risk-based prioritisation and securing capital funding to address the £33m of outdated equipment and ensure compliance with regulations. |
| EDoW | CRR24-15 | Health and Safety | 5 x 4 = 20 ↔ | 8 | People 4 - Seek | P&C | Newly developed strategic risk Feb 24, 4 actions identified, 0 completed, 4 progressing. All actions are on track against the 2024 target date. Further work is required to improve safe compliance. |
| EDoW | CRR24-16 | Leadership/Special Measures | 3 x 4 = 16 ↔ | 8 | Regulatory 3 - Open | P&C | New risk as of Dec 23. 7 actions identified, 3 completed, 1 overdue and 3 new actions . This risk is presented to the RMG and Executive Team in April for a proposed reduction in score as a result of completed actions the likelihood as reduced from a 4 to a 3, reducing the score from 16 to 12. Proposal rejected at Risk Management Group (09/04/2024) and Executive team (10/04/2024), score to remain as 16. P&C 11/04/24 feedback-To be further strengthened beyond scope of the Board and to reflect the risk of gap in substantive Executive Team |
| CDIO | CRR24-17 | ICT Failure and Cyber | 4 x 5 = 20 ↔ | 15 | Reputational 4 - Seek | PPPH | Newly developed strategic risk Feb 24, 7 actions identified, 2 completed, 5 progressing. Target score of 15 not in line with appetite. The main barriers are around securing investment for infrastructure and additional specialist posts to maintain security. 'Dependent on funding' noted on target date, 2025, (further |

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| | | | | | | treatments to be identified). PPHP 23/04/24 to address overdue actions prior to AC and Board. |
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Key:

| Committee | |
|---|-------|
| Performance, Finance and Information Governance Committee | PFIGC |
| Quality, Safety and Experience Committee | QSE |
| People & Culture Committee | PCC |
| Audit Committee | AC |

| Executive Lead | |
|---|-------|
| Executive Director of Workforce | EDoW |
| Executive Director of Nursing & Midwifery | EDoN |
| Executive Director of Finance | EDoF |
| Chief Digital Information Officer | CDIO |
| Executive Director of Public Health | EDoPH |
| Executive Director of Operations | EDoO |
| Executive Director of Therapies and Allied Health Professions | EDoTH |

| Trend | |
|---------------------------------|---|
| No trend/Score remains the same | ↔ |
| Increase | ↑ |
| Decreased | ↓ |

Appendix 2 - BAF Detailed Information

BAF Changes to report for review

| BAF SP14 | Executive: Executive Director of Finance | | Date Opened: 04/01/2024 | | | |
|---|---|--|--|--------------------|------------|-------|
| | Committee: Performance, Finance and Information Governance Committee | | Date Last Reviewed: 28/02/2024 | | | |
| | Strategic Priority: P14 Estates & Capital | Link to CRR: 24-06 Suitability and Safety of sites | Committee: NEW Due at PFIG 30/04/24 | | | |
| | | | Target Risk Date: 31/03/2035 | | | |
| There is a risk of failing to deliver and 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. | | | | | | |
| Mitigations / Controls | | Gaps in Controls | | Current Risk Score | | |
| <ol style="list-style-type: none"> Estates risk reviews to determine know high risk issues, review current mitigation and align capital funding request. Current capital plan has been risk assessed to ensure they address known high risk within capital financial limits. Pan BCUHB Operational Estates risk group has been formed to review and assess all infrastructure risks and develop an action plan. Estates Funding Advisory Board (EFAB) funding allocated by Welsh Government to focus on key themes – MHL, Fire, Decarbonisation and Infrastructure. | | <ol style="list-style-type: none"> Capital Programme to be focused on addressing highest risk issues to the Health Board. All capital request will be aligned to Datix risk register and funding will be determined by the executive team to ensure highest risk issues are resolved. The capital programme will align with findings of the 6 facet survey and focus on compliance, engineering infrastructure and building fabric / environment. The current estimated backlog maintenance costs associated with the Health Board is in the region of £350M. Inadequate resources and multiple constraints including finance, resulting in significant shortfall in capital funding to make an adequate impact on risk reduction. Unable to quantify the extent of the issue due to the lack on a 6 facet survey data. CRR 24-06 Suitability and Safety of Sites – Currently an open Corporate Risk | | Impact | Likelihood | Score |
| | | | | 5 | 4 | 20 |

| | | for the Health Board with a current risk score of 20. | |
|---|--|--|---|
| Actions and Due Date | | | |
| Action Detail | | | Due Date |
| 1. Capital Programme to be focused on addressing highest risk issues to the Health Board. All capital request will be aligned to Datix risk register and funding will be determined by the exec team to ensure highest risk issues are resolved. – Action – Exec to review capital allocation and confirm funding aligns with the risk appetite of the Health Board. | | | 31 st March 2024 |
| 2. Unable to quantify the extent of the issue due to the lack on a 6 facet survey data. – Action – Plan already in place and providing exec approve revenue funding to support the programme, Operational Estates will commence with a 5 year programme of survey works across the Health Board. | | | 31 st March 2029 |
| 3. Significant shortfall in capital funding to make an adequate impact on risk reduction. – Action – Development and submission of Business Cases to Welsh Government to resolve major infrastructure issues and reduce the Health Board’s Backlog Maintenance in line with the Estates Strategy. | | | 31 st March 2035 |
| Lines of Defence | | | Overall Assessment |
| 1 | 2 | 3 | <p>Three actions due end of March 2024, Committee to be provided with progress update and if risk can subsequently be reduced.</p> <p>Significant investment is required to enable the Health Board to reduce the risk score and current backlog maintenance. The current estimated backlog maintenance costs associated with the Health Board is in the region of £350m.</p> |
| <p>1. CPMT Existing groups in operation within the Health Board where capital prioritise are reported:</p> <ul style="list-style-type: none"> a. Capital Planning Management Team b. Capital Investment Group c. Performance Finance Information Governance d. Exec’s group <p>2. Existing groups in operation within the Health Board where environmental issues and safety are escalated:</p> <ul style="list-style-type: none"> a. Strategic Occupational Health and Safety Group | <p>1. Risk Management Group</p> <p>2. Executive Team</p> <p>3. Performance, Finance and Information Governance Committee</p> | <p>1. Internal Audit</p> <p>2. NHS Wales Shared Services Partnership – Specialist Estates Services</p> | |

| | | | |
|---|--|--|--|
| b. Strategic Infection Prevention Group | | | |
|---|--|--|--|

Annual Plan for Reference

Strategic Priority P14
Estates & Capital: key actions for 23/24

| Ref | Organisational Delivery Objective | Lead | Specific Ministerial or Special Measures Priority | WG Quad. Aim | Completion Timescales (quarters) |
|-------|--|------|---|--------------|----------------------------------|
| P14.1 | Implement the key national and local discretionary capital programmes including: | DOF | | QA2 & 4 | Q1 – Q4 |
| | ▪ Health and safety, risk and statutory compliance | | | | ◆◆◆☒ |
| | ▪ Fire compliance | | | | ◆◆◆☒ |
| | ▪ Planned and unscheduled care and patient experience | | | | ◆◆◆☒ |
| | ▪ Mental health | | | | ◆◆◆☒ |

| | | | | | |
|-------|--|-----|--|-----|---------|
| | <ul style="list-style-type: none"> Sustainability including decarbonisation | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Medical Devices replacement programme | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Informatics | | | | ◆◆◆☒ |
| P14.2 | Progress the major Capital programme Schemes, including: | DOF | | QA2 | Q1 – Q4 |
| | <ul style="list-style-type: none"> Wrexham Maelor Continuity Programme | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Ysbyty Gwynedd Compliance Programme | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Nuclear Medicine/PET CT | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Radiotherapy programme | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Royal Alexandra Development Project | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Integrated Primary Care Resource Centre | | | | ◆◆◆☒ |
| | <ul style="list-style-type: none"> Ablett Unit redevelopment FBC | | | | ◆◆◆☒ |

| | | | |
|--------------------------------------|--|---|--|
| BAF Board leadership & governance | Executive: Board Secretary | | Date Opened: 19 October 2023 |
| | Committee: People & Culture Committee | | Date Last Reviewed: 25/03/24 |
| | Strategic Priority: SP16 | Link to CRR: Leadership/Special Measures Link to Tier 1's: 4480/3969 | Last Date Reviewed at Committee: 11/04/2024 |
| | | | Target Risk Date: February 2024 |

There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.

| Mitigations | Gaps in Controls | Current Risk Score | | |
|--|---|--|------------|-------|
| | | Impact | Likelihood | Score |
| <ol style="list-style-type: none"> The development and agreement of the Special Measures “Governance and board effectiveness domain” deliverables and milestones that give clarity on what needs to be delivered by when. This includes development of Board Development and Board Induction products to support Board arrangements. This is detailed in the action section. Close working with Welsh Government on the recruitment of new Board members through the public appointment process. Comprehensive response to the Board Effectiveness Review by Audit Wales that aligns to the Special Measures approach. | <ol style="list-style-type: none"> Welsh Government control the public appointment but progression updates are provided The implementation of the review of the OBS is reliant upon following the organisational change policy and this will impact timescales for that part of the improvements The appointment of some Executive appointments is reliant on the timely review of the Exec Portfolio review | 4 | 3 | 12 |
| | | Movement N/A | | |
| | | Revised score Impact 4 remains and likelihood reduced from 4 to 3 March 2024 in line with Target | | |
| Actions and Due Date | | | | |
| Target Date | | | | |
| SM Ref no C1-1.3: Implement phase 1 induction for all Board members | | Nov-23 | Completed | |

| SM Ref no C1-1.4: Develop phase 1 Board development programme | Dec-23 | Completed | |
|--|---|----------------------------|-------------------------|
| SM Ref no C1-1.5: All committees with assigned IMs operational, including ToR, Corp Calendar and Workplans | Mar-24 | Completed | |
| SM ref no C1-1.6: Design Risk management framework and commence implementation | Dec-23 | Completed | |
| SM ref no C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases | Mar-24 | Exec recruitment commenced | |
| SM ref no C2-1.8: OBS team – implement interim and design permanent structure | Dec-23 | Underway | |
| SM ref no C2-1.9: Policy management and implementation/audit approach agreed | Oct-23 | Completed | |
| Feedback from Audit Wales follow up review – December 2023 | Dec-23 | Completed | |
| Scrutiny of progress through Audit Committee | November 2023, January 2024 and March 2025 | Completed | |
| Assurance on progress through Board | November 2023, January 2024 and March 2026 | Completed | |
| Lines of Defence | | | Overall Assessment |
| 1 | 2 | 3 | Most actions completed. |
| Special Measures meeting and assurances to committees on 90 day plan. OBS Team Meetings. | Acting Board Secretary providing recommendations and progress updates through the Executive Team meetings | Internal Audit | |

Annual Plan for Reference

Strategic Priority P16

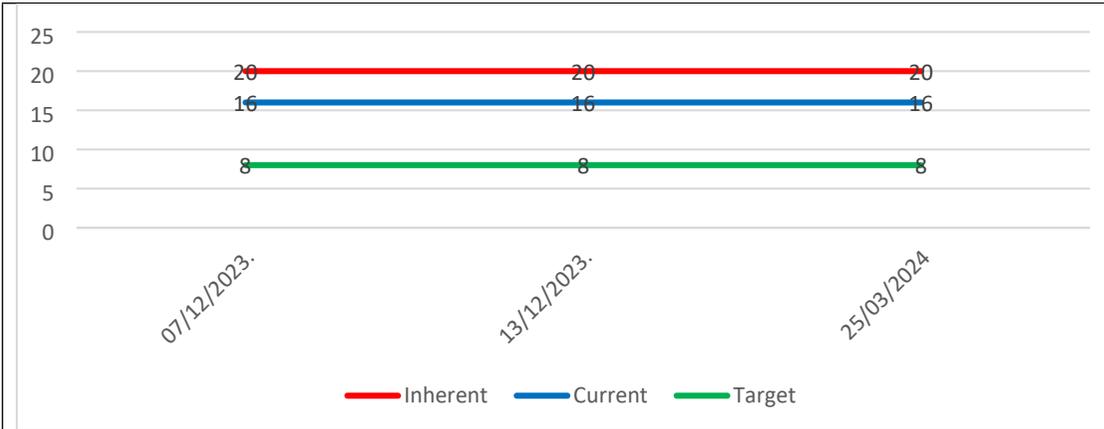
Board leadership & governance: key actions for 23/24

| Ref | Organisational Delivery Objective | Lead | Specific Ministerial or Special Measures Priority | WG Quad. Aim | Completion Timescales (quarters) |
|-------|---|------|---|--------------|----------------------------------|
| P16.1 | Implement the actions in the Special Measures Response Plan 90 day cycles, including: | DTSP | SM | QA4 | |
| | <ul style="list-style-type: none"> Strengthening Board Effectiveness and invest in Board Development | | | | ??? |
| | <ul style="list-style-type: none"> Supporting Independent member recruitment | | | | ??? |
| | <ul style="list-style-type: none"> Executive Team Development | | | | ??? |
| | <ul style="list-style-type: none"> Risk Management Framework | | | | ??? |
| | <ul style="list-style-type: none"> Board Committee | | | | ??? |
| | <ul style="list-style-type: none"> Special Measures Assurance Approach | | | | ??? |
| P16.2 | Develop and implement an organisational Performance Framework | DOF | | QA2 | |
| | <ul style="list-style-type: none"> Revised performance and accountability arrangements to be in place | | ??? | | |
| P16.3 | Develop a Health Board Planning Framework, taking into account the findings of the Planning Review as part of the Special Measures response | DTSP | SM | QA2 | |
| | <ul style="list-style-type: none"> Planning review to be undertaken from July 2023 with report anticipated in September 2023 | | | | ??? |

Appendix 3 - Full Corporate Risk Register Detailed Information

| CRR 24-01 | Risk Title: People, Culture and Wellbeing | | Date Opened: 07/12/2023 |
|--|--|--------------------------|--|
| | Assuring Committee: People & Culture Committee | | Date Last Committee Review: 11/04/24 |
| Date Last Reviewed: 25/04/2024 | Director Lead: Deputy Director of Workforce | Link to BAF: SP12 | Target Risk Date: 30/09/2024 |
| <p>There is a risk that BCU do not have a highly skilled, engaged and motivated workforce which could impact on safe delivery of care. This could be caused by staffing shortfalls, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.</p> | | | |
| Mitigations/Controls in place | Lines of Assurances | | Additional Controls required |
| <ol style="list-style-type: none"> 1. People Committee to oversee delivery of the People Services agenda 2. Local IHC & Pan Services People & Culture Committees in place 3. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 4. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 5. The Recruiting well and Joining Well programmes in place 6. Organisational Retention lead in post for BCU linked with national retention work through HEIW 7. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 8. Current BCU Flexible working policy has been updated and is in place 9. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 10. Speak out Safely MDT in place 11. Work in Confidence platform for staff to safely raise concerns. 12. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board | 1st – eg. Local Assurances: <ol style="list-style-type: none"> 1. Organisational Development Steering Group 2. People Services Senior Leadership Team 3. Risk Management Group 4. Executive Team oversight | | <ol style="list-style-type: none"> 1. The programme of work through the Education and Learning Committee to be finalised 2. Increased measures on employee engagement 3. Development of a programme of work to ensure line manager's full involvement in employee engagement 4. Feedback from the HEIW Nurse retention tool. |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> 1. People & Culture Committee 2. Progress towards the People Service agenda is reported through the People & Culture Committee chaired by the CEO and reported to the Board. | | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> 1. Internal Audit 2. Welsh government through quarterly IQPD meetings with executive team 3. HEIW through National Retention programme meetings | | |
| | | | |

| Actions | Due Date | Progression Analysis | |
|---|----------------------|----------------------------|-------|
| Education and Learning Committee is being established as a control measure | 31.07.24 | New action | |
| NHS Staff Survey action plan to be developed and implemented across 24/25 | 30.06.24 | New action | |
| Scoping and methodology proposal for the wider review of the 2022 Operating Model restructure agreed via an appropriate Executive governance process following appropriate engagement. Proposal shared at OD Steering group. Process of gathering feedback underway in April and May 2024. | 30/05/2024 | Revised Date (overdue) | |
| Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed | 15/06/2024 | Revised Date (Progressing) | |
| Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles. Recommendations made were reviewed by the Organisational Development Steering Group on 5.2.24. As agreed there, further work is being undertaken to understand the barriers to engagement of clinicians, which will inform proposals for the development of a broader corporate engagement offer. A draft OD Plan was presented to the Steering Group on 4.3.24 for feedback before being finalised. | 29/02/2024 | Complete | |
| Measure employee engagement: Proposal on a broad range of mechanisms to do this other than just the staff survey presented via an appropriate Executive governance process. Proposal was presented at OD Steering Group on 04/03/2024. | 29/02/2024 | Complete | |
| Formal Culture Change Plan and accompanying Comms and Engagement plan presented via an appropriate Executive governance process. Proposal was presented and agreed at the OD Steering Group on 04/03/2024. Resources to deliver the plan still need to be agreed. | 29/02/2024 | Complete | |
| Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan. Top level data has been received. The final local picture of the NHS survey will not be received until May 24. | 29/02/2024 | Complete | |
| Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24 | 30/04/2024 | Revised Date (Progressing) | |
| Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts. This will enable improvements in a wide range of organisational outcomes, such as quality, access, experience. Version 1 of staff-facing LOF finished and ready for testing with colleagues in MHL, as well as with critical friends and colleagues in our 'community of practice' too. | 29/02/2024 | Complete | |
| The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce | TBC | New action | |
| | Impact | Likelihood | Score |
| | Inherent Risk Rating | 4 | 5 |
| | | | 20 |



| | | | |
|---------------------|--------|---|----------|
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 2 | 4 | 8 |
| Risk Appetite | People | | 4 - Seek |

Rationale for Corporate Risk

This is a corporate risk due to the current position across the Health Board with high turnover rates across certain key staff groups. Staff engagement score at 72%, comparable with all Wales average of 73%.

| | | | |
|--|---|-------------------------|---|
| CRR 24-02 | Risk Title: Patient Safety - Falls | | Date Opened: 01/12/2023 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/24 |
| Date Last Reviewed: 28/02/2024 | Director Lead: Executive Director of Nursing and Midwifery | Link to BAF: N/A | Target Risk Date: 30/04/2024 |

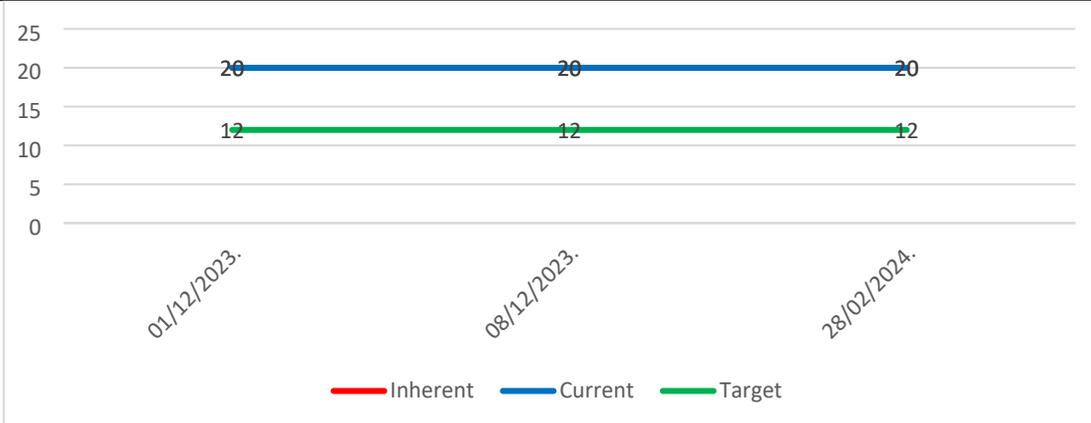
There is a risk to patient safety, in particular harm, as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, compliance with **manual handling training**, compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|--|
| <p>1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%.</p> <p>2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months.</p> <p>3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager.</p> <p>4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards:</p> <p>5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards.</p> <p>6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.</p> | <p>1st – eg. Local Assurances:</p> <ol style="list-style-type: none"> Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. Ward accreditation metrics Ward accreditation review process Peer reviews Patient Safety Group Risk Management Group Executive Team Meeting | <ol style="list-style-type: none"> Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. Assurance and training of agency workers. Improved compliance with manual handling training. Sustained improvement in the quality of completion of FBHMA. |
| | <p>2nd – eg. Board/Committee Assurances:</p> <ol style="list-style-type: none"> Quality, Safety and Experience Committee | |
| | <p>3rd – eg. External Assurances:</p> | |

| | | |
|--|--|--|
| 7. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete | <ol style="list-style-type: none"> 1. Internal Audit 2. HSE 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews | |
|--|--|--|

| Actions | Due Date | Progression Analysis |
|--|-----------------|-----------------------------|
| New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched. Policy approved at Patient Safety Group, disseminated and uploaded to Betsinet | 30/12/2023 | Completed |
| Audit of Ward Managers induction for agency/temporary staff to ensure falls training has been completed. | 30/04/2024 | Progressing |
| Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce | 30/04/2024 | Progressing |
| Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity | 30/04/2024 | Progressing |
| Outcome of peer review pilot to be evaluated | 30/04/2024 | Progressing |
| Future enhancement to the Welsh Nursing Care Record on an all-Wales basis. | 30/04/2024 | Progressing |

| | | Impact | Likelihood | Score |
|-------------------------------------|----------------------|---------|------------|----------|
| | Inherent Risk Rating | 4 | 5 | 20 |
| | Current Risk Rating | 4 | 5 | 20 |
| | Target Risk Score | 4 | 3 | 12 |
| | Risk Appetite | Quality | | 3 - Open |
| Rationale for Corporate Risk | | | | |



N.B. Inherent and Current score lines stacked as both are 20.

This is in line with the Falls Internal Audit limited assurance report. Disproportionate high number of avoidable falls across the Health Board compared to other NHS providers.

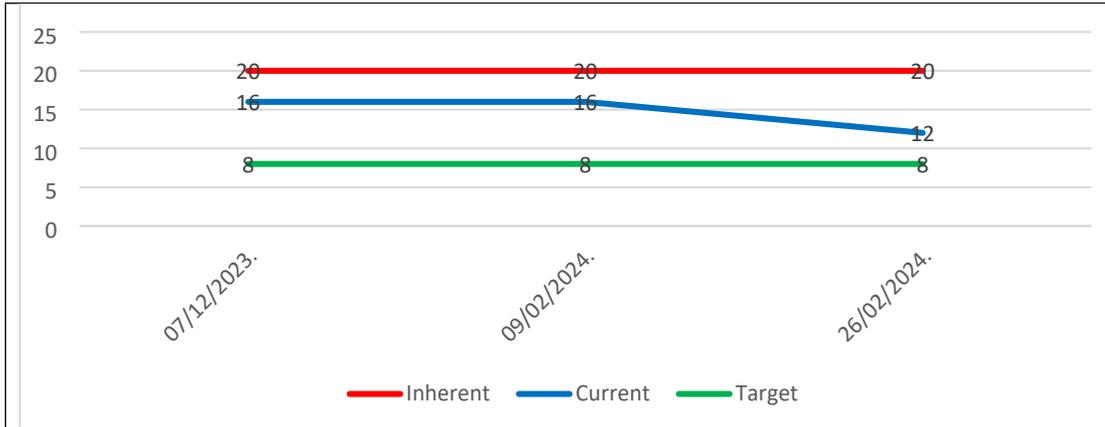
| | | | |
|--|--|-------------------------|---|
| CRR 24-03 | Risk Title: Safeguarding | | Date Opened: 07/12/2023 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/2024 |
| Date Last Reviewed: 26/02/2024 | Director Lead: Executive Director of Nursing and Midwifery | Link to BAF: N/A | Target Risk Date: 31/03/2025 |

There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance, insufficient workforce training** and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may result in harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Safeguarding legislation which includes but is not exclusive to the Social Services and Wellbeing (Wales) Act 2014, the Deprivation of Liberty Safeguards, and the Mental Capacity Act.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|---|---|
| <p>1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks.</p> <p>2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework.</p> <p>3. BCUHB mandatory safeguarding training is in place for all staff.</p> <p>4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds.</p> <p>5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government.</p> <p>6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC).</p> | <p>1st – eg. Local Assurances:</p> <ol style="list-style-type: none"> Safeguarding Risk Management Group Executive Team Meeting | <p>1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control.</p> <p>2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions.</p> <p>3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance.</p> <p>4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings.</p> <p>There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Health Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced leadership team capacity due to absences. .</p> |
| | <p>2nd – eg. Board/Committee Assurances:</p> <ol style="list-style-type: none"> Quality, Safety and Experience Committee | |
| | <p>3rd – eg. External Assurances:</p> <ol style="list-style-type: none"> Internal Audit Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. | |

| | | |
|--|---|--|
| 7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews. | 4. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation. | A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures. |
|--|---|--|

| Actions | Due Date | Progression Analysis | |
|--|------------|----------------------|-------|
| Review of the safeguarding team and structure A review of the safeguarding team structure has started, a report will be submitted in April 2024 | 30/04/2024 | Progressing | |
| National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024. Welsh Government delay until Sept 2024. | 31/03/2025 | Progressing | |
| Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP', Approved at SGPG being shared at QDG during February 2024. Progressing through internal governance. | 31/03/2024 | Completed | |
| North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, multi-agency discussions ongoing. | 30/06/2024 | Progressing | |
| Development of a DoLS/CoP DoL Standard Operating Protocol (SoP), almost complete. | 31/05/2024 | Progressing | |
| CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration, dependent on CNO. | 30/03/2024 | Progressing | |
| Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices | 31/05/2024 | Progressing | |
| | Impact | Likelihood | Score |
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 3 | 12 |



| | | | |
|-------------------|---------|---|----------|
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

Safeguarding legislation adherence continues to be progressed and a priority and controls are in place to address risk, in collaboration with national partners. While full compliance is taking longer than desired due to dependencies nationally and outside the control of the Health Board, the team have confidence in robust controls to manage risks in the interim while awaiting further national guidance. Actions to date have positioned us well, and the team remain committed to achieving full alignment as soon as the required national guidance and legislation are available. While there remain to be some gaps in controls and full completion of actions this will be continue to be progressed and managed operationally by the team. The likelihood of public scrutiny is reduced to a 3.

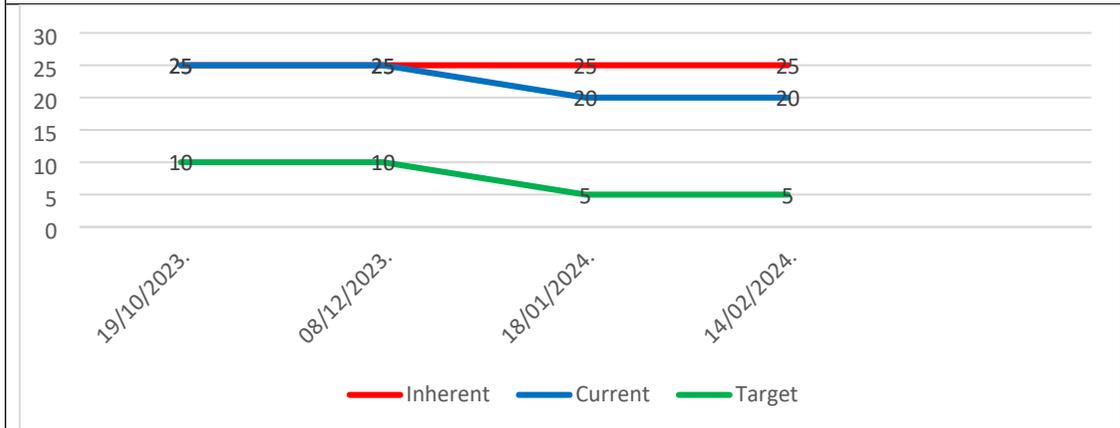
| | | | |
|--|---|--|---|
| CRR 24-04 | Risk Title: Failure to Embed Learning | | Date Opened: 19/10/2023 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/2024 |
| Date Last Reviewed: 14/03/2024 | Director Lead: Executive Director of Nursing and Midwifery | Link to BAF: SP18 - Quality, Innovation and Improvement | Target Risk Date: 30/06/2024 |

There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|--|--|--|
| <ol style="list-style-type: none"> 1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports 12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans | 1st – e.g. Local Assurances: <ol style="list-style-type: none"> 1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) 3. Executive performance reviews with IHCs 4. Risk Management Group 5. Executive Team Meeting 6. Clinical audit 7. Regulatory Assurance Group and oversight/assurance reporting 8. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report | <ol style="list-style-type: none"> 1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests |
| | 2nd – e.g. Board/Committee Assurances: <ol style="list-style-type: none"> 1. Executive performance reviews with IHCs 2. Quality, Safety and Experience Committee oversight of quality issues | |

| <p>13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings</p> | <p>3rd – e.g. External Assurances:</p> <ol style="list-style-type: none"> 1. Internal Audit 2. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 3. WG performance monitoring and assurance 4. Welsh Government Reviews 5. Royal College Reviews | | |
|---|--|------------|---------------------------------|
| Actions | | Due Date | Progression Analysis |
| <p>The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository</p> <p>This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June 24</p> | | 30/06/2024 | Date Revised from March 2024 |
| <p>Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements</p> <p>This work is being taken forward with the support of the NHS Wales Executive</p> | | 30/06/2024 | Date Revised from March 2024 |
| <p>A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data</p> <p>Work is progressing on the Dashboard and a test version is live however technical issues remain in extracting and presenting data – it is hoped to launch the Dashboard in April 2024</p> | | 30/04/2024 | Date Revised from December 2023 |
| <p>A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning.</p> <p>Update - This was due end of March – the aim is still to have a working test launched for April 2024</p> | | 30/04/2024 | Date Revised from March 2024 |
| <p>The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed</p> <p>This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June</p> | | 30/06/2024 | Date Revised from March 2024 |

| | | |
|--|------------|------------------------------|
| <p>The new Quality Strategy will be developed through a co-design process</p> <p>A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies.</p> | 31/05/2024 | Date Revised from March 2024 |
| <p>A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system</p> <p>Update - The initial draft of a QMS is due at Board in May 2024. Therefore, the deadline will be extended. A QMS working group is in place, the first meeting was 13 December 2023. There was a workshop at the Executive Team on 24/01/24, at the Senior Leadership Team on 30/01/24, and at the Board on 29/02/24. The Quality Team visited ELFT (an Outstanding rated English Trust) on 26/02/24. The Quality Team are part of the all-Wales working group. Research has been undertaken into work in Wales and Scotland. Support is being provided by Improvement Cymru and the NHS Wales Executive National Quality Team. We plan two further meetings of the working group, and a wider engagement workshop in April May 2024 – Revised date from 03/24 to 05/24 due to external dependencies</p> | 31/05/2024 | Date Revised from March 2024 |



| | Impact | Likelihood | Score |
|----------------------|--------------|------------|----------|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 1 | 5 |
| Risk Appetite | Reputational | | 4 - Seek |

Rationale for Corporate Risk

Significant backlog of incidents waiting investigation and new cases demonstrating learning has not been embedded

| | | | |
|--|--|-------------------------|--|
| CRR 24-05 | Risk Title: 2023/24 Financial Plan | | Date Opened: 13/03/2023 |
| | Assuring Committee: Performance, Finance and Information Governance Committee | | Date Last Committee Review: 22/02/2024 Due for review at PFIG 30/04/2024 |
| Date Last Reviewed: 13/03/2024 | Director Lead: Executive Director of Finance | Link to BAF: N/A | Target Risk Date: 31/03/2024 |

Failure to achieve the Annual Plan for 2023/24 (£134.2m deficit), due to non-delivery of planned level of financial improvement

The financial plan for 2023-24 has identified a forecast deficit of £134.2m. This includes a target for financial improvement of £38.7m, which is based on the following:

- Disinvestment identified £13.5m
- Savings Target £25.2m (Stretch Target £30m)

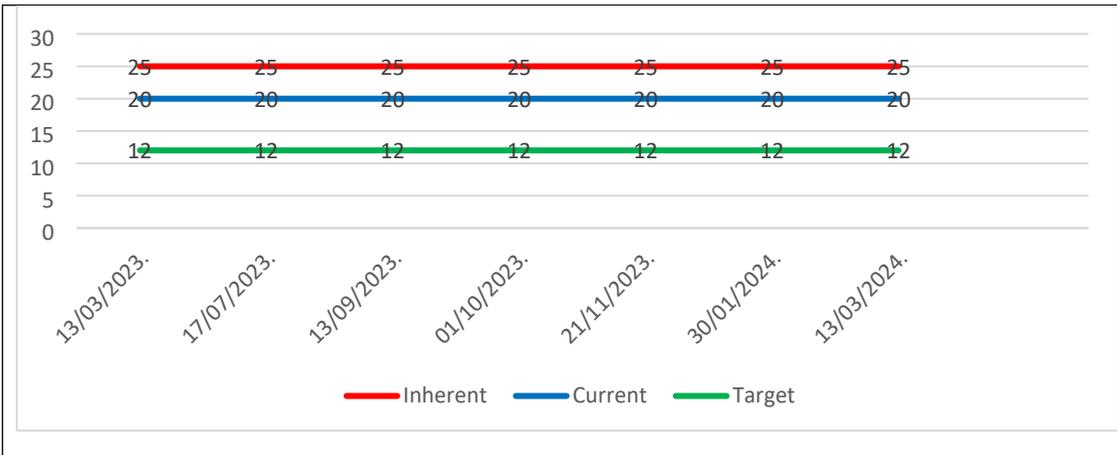
Failure to deliver the target for financial improvement could adversely impact on the achievement of the financial plan and increase the deficit.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|---|
| <ol style="list-style-type: none"> 1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions has been agreed to meet at senior leadership team SLT and performance to be challenged at EDIPG. 2. Cross cutting themes with Executive leadership have also been agreed to support IHC/other delivery. 3. Introduction of the Recurrent Investment Group Assurance (RIGA) to assess the £100m Annual Plan investment (Phase 1). 4. Introduction of the Establish Control Group to review all requests for A&C posts and all Band 7+ posts (Non-Patient Facing) and to obtain Executive approval before advertising and reduction of Interim Corporate Staff from 52 to 7. 5. Internal reporting by Department on a monthly basis including review of overspends and forecasts. 6. Financial reporting to Welsh Government on a monthly basis, with the MMR. | 1st – eg. Local Assurances: <ol style="list-style-type: none"> 1. CEO led Divisional Performance Management of Directors at IPEDG and individual performance reviews 2. Control Total Actions and Monitoring of Progress 3. Regular review of Risks and Opportunities for mitigation 4. Regular Check and Challenge meetings between FD's and CFOs and Divisional Directors on in-month\forecast outturn and savings delivery 5. Risk Management Group 6. Executive Team Meeting | <ol style="list-style-type: none"> 1. Welsh Government (WG) expectation to achieve a control total deficit of £20m. Delivery of control target may result in the £82m previous WG funding support plus the new 23/24 £76m investment, becoming recurrent funding in 2024/25. |
| | 2nd – eg. Board/Committee Assurances: | |
| | <ol style="list-style-type: none"> 1. Performance, Finance and Information Governance Committee /Audit Committee 2. Board Committee | |
| | 3rd – eg .External Assurances: | |

| | | |
|---|--|--|
| <p>7. Financial (including Savings and Finance Special Measures Action Plan) oversight arrangements in place through the Performance, Finance and Information Governance Committee (PFIG)</p> <p>8. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent rather than non-recurrent.</p> <p>9. Additional £101m (£76m conditionally recurrent) provided by Welsh Government, reducing the deficit from £134m to £33m at Month 7.</p> <p>10. Standing Financial Instructions updated to reflect the model issued by Welsh Government and Scheme of Reservation and Delegation (SoRD) strengthened</p> | <p>1. Internal Audit</p> <p>2. WG in the form of a monitoring return submission – detailing for example, expenditure run rates and reasons for movements, savings profile delivery and risks and mitigating actions.</p> <p>3. Fortnightly performance meeting with the WG and NHS Executive and submission of a Finance: Special Measures Action Plan</p> | |
|---|--|--|

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Recurrent Investment Group Assurance (RIGA) to assess the £42m Investments Plan (Phase 2). | 31/03/2024 | Progressing |
| <p>Application of Control Totals to Divisions to reduce expenditure by 2% between November and March 2024</p> <p>Month 11 - Year to date deficit above plan significantly reduced – now only requires a £2.7m surplus to be posted in the final month of March to achieve the £33m outturn position. Further opportunities are currently being considered which will reduce the outturn to c £27m by year end. Whilst this does not achieve the control total of £20m deficit set by WG, it demonstrates progress and is an improvement against the original planned outturn.</p> <p>Month 11 - The Health Board is forecast to deliver £34.3m Savings, £9.4m Accountancy Gains and generate additional Income of £0.6m, totalling £44.2m and therefore exceeding the target (£25.2m) and the stretch target (£30.9m). Of these forecast savings £21.3m is identified as recurring, with a full year effect of £27.6m</p> | 31/03/2024 | Progressing |

| | Impact | Likelihood | Score |
|----------------------|-----------|------------|--------------|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Financial | | 2 – Cautious |



Rationale for Corporate Risk

Reduction in current risk score from 20 to 16 - Year to date deficit above plan significantly reduced – now only requires a £2.7m surplus to be posted in the final month of March to achieve the £33m outturn position

| | | | |
|--|--|--------------------------|---|
| CRR 24-06 | Risk Title: Suitability and Safety of Sites | | Date Opened: 04/01/2024 |
| | Assuring Committee: Performance, Finance and Information Governance Committee | | Date Last Committee Review: New risk due for review at PFIG 30/04/24 |
| Date Last Reviewed: 28/02/2024 | Director Lead: Executive Director of Finance | Link to BAF: SP14 | Target Risk Date: 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will be submitted to Welsh Government – completion target date 2035). |

There is a risk that the suitability and safety of the estates and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and unsuitable buildings, backlog maintenance issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.

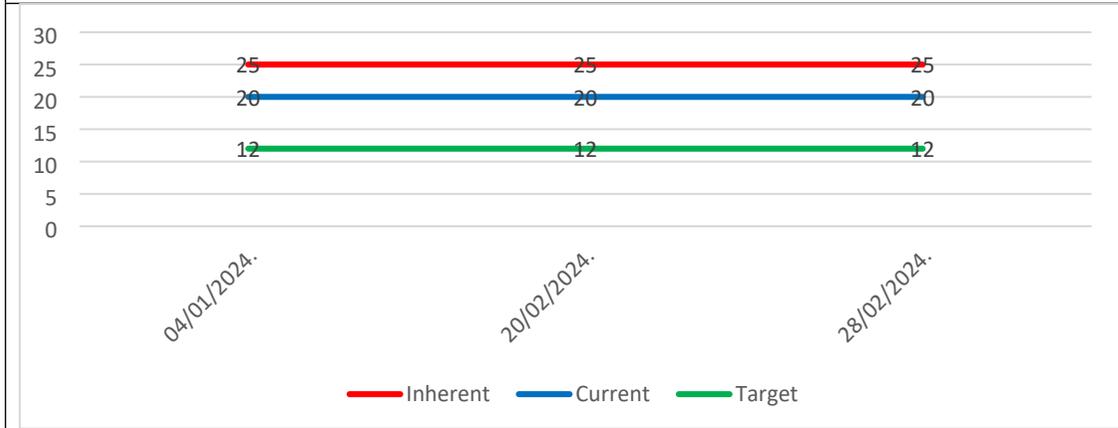
| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|---|
| <ol style="list-style-type: none"> Estates Strategy developed and approved by the Health Board in January 2023. Internal Governance for capital allocation in place within the Health Board. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. Discretionary Capital Allocation of £12.448m for 24/25 approved by Welsh Government with an allocation of approximately £3.208m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise | <p>1st – eg. Local Assurances:</p> <p>Existing groups in operation within the Health Board where capital prioritise are reported:</p> <ol style="list-style-type: none"> Capital Planning Management Team Capital Investment Group Risk Management Group Executive Team meeting <p>Existing groups in operation within the Health Board where environmental issues and safety are escalated:</p> <ol style="list-style-type: none"> Strategic Occupational Health and Safety Group Strategic Infection Prevention Group Risk Management Group | <ol style="list-style-type: none"> 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate. Assurance around the development control plan aligned with both the Estates strategy and the Clinical strategy. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team. Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams. Ensure that the Health Board Capital prioritisation plan is shared with Welsh Government (WG) to identify required investment. The end date is dependant of how |

| | | |
|--|---|---|
| <p>concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff.</p> <p>7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below</p> <p>a) Fire Management</p> <p>b) Asbestos Management</p> <p>c) Water Safety,</p> <p>d) Ventilation Safety</p> <p>e) Electrical Safety</p> <p>8. Welsh Government Capital Resource Meetings in place to provide route for escalation.</p> <p>9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance</p> | <p>8. Executive Team meeting</p> <p>9. Internal Audit</p> <p>2nd – eg. Board/Committee Assurances:</p> <p>1. Performance, Finance and Information Governance Committee</p> <p>3rd – eg. External Assurances:</p> <p>Internal Audit</p> <p>External Audits undertaken by NHS Wales Shared Services Partnerships, Specialist Estates Services, Authorising Engineers in the following disciplines:</p> <p>a. Fire</p> <p>b. Water Safety</p> <p>c. Ventilation</p> <p>d. Electrical (HV / LV)</p> <p>e. Medical Gases</p> <p>f. Decontamination</p> <p>Inspections by the North Wales Fire and Rescue service within inpatient areas.</p> | <p>much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.</p> <p>6.Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.</p> <p>7.Updated agreed protocol for use of Annual Discretionary Slippage to be put in place by developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.</p> |
|--|---|---|

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Business Case Review Group to be developed by Health Board. | 29/02/2024 | Overdue |
| Completion of Welsh Government Prioritisation exercise | 31/03/2024 | Progressing |
| Undertake action to deliver an Health Board Estates Rationalisation Programme | 31/03/2024 | Progressing |
| Agreed protocol for use of Annual Discretionary Slippage to be put in place | 31/03/2024 | Progressing |
| Review / Standardisation of IHC's / Mental Health Learning Disability Estates and Capital Group 'Terms of Reference' and escalation process | 30/09/2024 | Progressing |

| | | |
|---|------------|-------------|
| Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years | 31/03/2026 | Progressing |
|---|------------|-------------|

| | | |
|---|------------|-------------|
| Review and update Development Control Plans | 30/04/2025 | Progressing |
|---|------------|-------------|



| | Impact | Likelihood | Score |
|----------------------|---------|------------|-------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 2 | 4 | 8 |
| Risk Appetite | Quality | | 3 |

Rationale for Corporate Risk

Current Risk score of 20 aims to be reduced to a 12 by April 2035.

Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.

Our estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board.

To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.

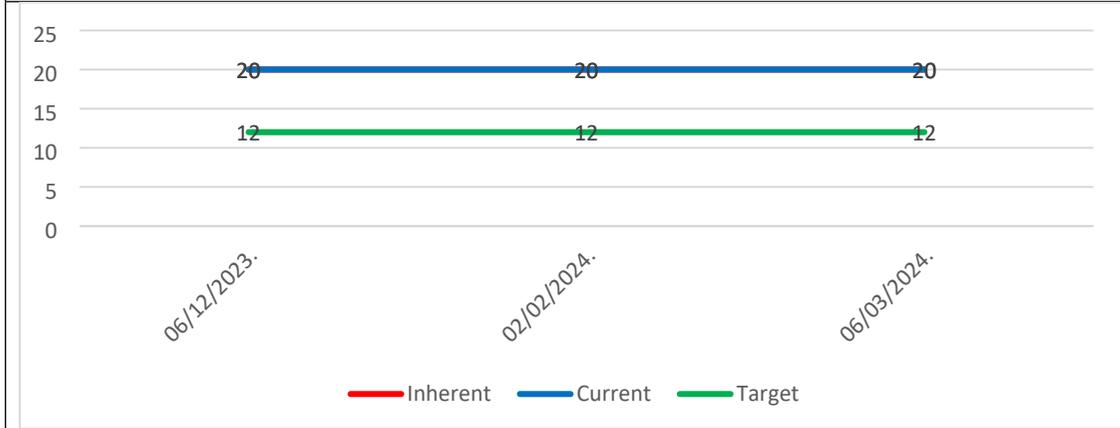
| | | | |
|--|--|--------------------------|---|
| CRR 24-07 | Risk Title: Availability and Integrity of Patient Information | | Date Opened: 06/12/2023 |
| | Assuring Committee: Planning, Population Health & Partnership Committee | | Date Last Committee Review: 23/04/2024 |
| Date Last Reviewed: 25/04/2024 | Director Lead: Chief Digital and Information Officer | Link to BAF: SP13 | Target Risk Date: 31/03/2029 |

There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling which could lead to deaths and harm.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|--|
| <ol style="list-style-type: none"> Current paper file identified as the Master Copy of the full record. Access to current clinical systems to print clinical information ready to store in the Master File. CITo Contract in place as a potential document repository. | 1st – eg. Local Assurances: | <ol style="list-style-type: none"> Establish and implement the governance arrangements for overall management of the Electronic Health Record. This will be captured as part of the full business case requirement. Lack of current system capabilities systems to integrate into the fuller Electronic Health Record. Full optimisation programme underway to review all current systems interoperability and functionality. Availability of current paper records within digital environment. Full Business Case will analyse resource requirements to consider scanning or dual processing of records. Patient Records Group currently not meeting. A review of the remit and establishment underway with the Senior Information Risk Owner and Caldicott Guardian. |
| | <ol style="list-style-type: none"> Information Governance Toolkit embedded with operational group oversight and monitoring. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee which focuses on performance indicators. Risk Management Group Executive Team meeting | |
| | 2nd – eg. Board/Committee Assurances: | |
| | <ol style="list-style-type: none"> Partnerships, People and Population Health Committee | |
| | 3rd – eg. External Assurances: | |
| <ol style="list-style-type: none"> Internal Audit Annual Information Governance Compliance Audit. Information Commissioners Office Audit. | | |

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Assessment to be undertaken of what is required for the development of an Outline Business Case for an Electronic Health Record (EHR) | 30/12/2024 | Progressing |
| Seeking approval and funding for the Strategic outline case for Electronic Health Record | 31/12/2024 | Progressing |

| | | |
|--|------------|-------------|
| Establish the cost and resource requirements to back scan all live records | 31/01/2025 | Progressing |
| Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams | 31/03/2025 | Progressing |
| Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record | 30/04/2025 | Progressing |
| Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project) | 30/04/2025 | Progressing |



N.B. Inherent and Current score lines stacked as both are 20

| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition the financial and resource requirement to implement the controls and mitigations required are significant.

| | | | |
|--|---|-------------------------|---|
| CRR 24-08 | Risk Title: Population Health | | Date Opened: 01/11/2023 |
| | Assuring Committee: Partnerships, People and Population Health Committee | | Date Last Committee Review: 23/04/2024 |
| Date Last Reviewed: 18/03/2024 | Director Lead: Executive Director of Public Health | Link to BAF: SP1 | Target Risk Date: 31/03/2026 |

There is a risk that the Health Board fails to adequately support the improvement of population health and reduce health inequalities. This may be caused by a lack of sustainable services, financial and resource constraints within the Health Board, dependency on grant funding to support prevention activity and demand for delivering the urgent and immediate healthcare needs of the population.

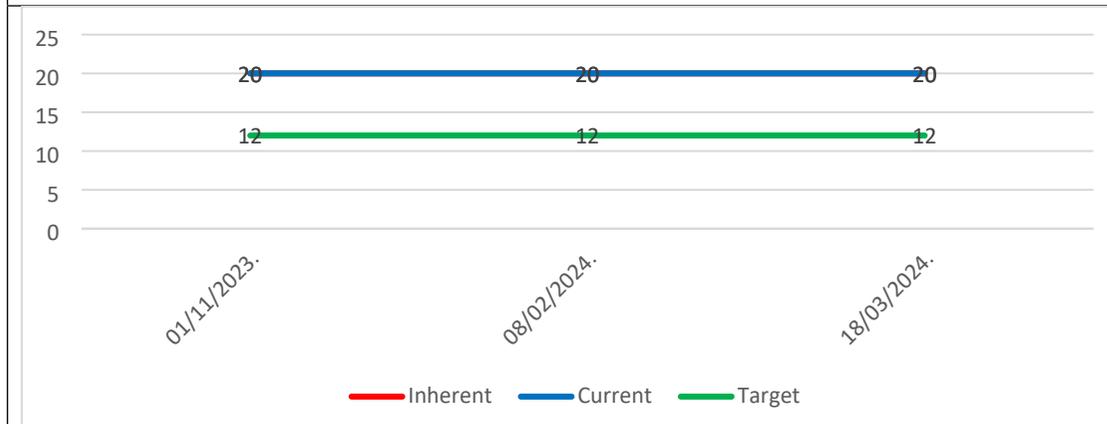
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic factors or the accessibility of health care services.

This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to increasing rates of infectious disease such as: Hepatitis, Measles, Mumps, Rubella, HIV, E-Coli, sexually transmitted infections. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|---|--|
| <ol style="list-style-type: none"> Population Health Executive Delivery Group (meets monthly) provides strategic direction. Planning, Population Health and Partnership Committee has oversight and receives regular reports. Welsh Government provides oversight of grant funded activity supporting prevention and early years. The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Public Health Team. **The Deputy Director of Public Health is currently Acting Executive Director of Public Health. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise and guidance. | 1st – eg. Local Assurances: <ol style="list-style-type: none"> Population Health Executive Delivery Group and the Public Health Senior Leadership Team. The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. | <ol style="list-style-type: none"> In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increasing the activities required. It is acknowledged that this is a long term risk which cannot be mitigated and fully evidenced within 1-3 years as is well documented through evidence and research. As a Health Board we will work |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> Health Board progress is reported to Regional Partnership Board and PPPH Committee. | |

| | | |
|---|---|---|
| <p>6. Public Health Team provide review and feedback on planning applications.</p> <p>7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of risks and issues.</p> | <p>2. A 'Whole System Approach' is being implemented across a number of key priority areas</p> <p>3. Annual development of Public Health work plan to reflect current and emerging need.</p> <p>4. The Health Protection Team have established funding in 24/25 Health Board allocation.</p> | <p>with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success.</p> <p>4. Investment in prevention at the levels required within the health board through investment of core funding.</p> |
| | <p>3rd – eg. External Assurances:</p> <p>1. Internal Audit</p> <p>2. Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums.</p> <p>3. A number of national programmes of work are underway including implementing the Weight Management Pathway and Smoke Free Sites regulations.</p> <p>4. National Performance Framework measures.</p> <p>5. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects</p> | <p>5. Partners within geographic area ability to commit resources at required levels to population health and prevention activity due to financial and capacity constraints</p> <p>6. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand.</p> <p>7. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale.</p> <p>8. The current cost of living crisis will adversely affect those most at risk.</p> <p>9. The current financial position of the Health Board and its partners will impact on investment and delivery of programmes which support this work.</p> <p>10. The current position of the Health Board within escalatory measures and associated short term focus to meet ministerial and special measures priority actions may reduce focus on longer term priority work aimed at prevention and early intervention.</p> <p>11. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available.</p> <p>12. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.</p> |

| Actions | Due Date | Progression Analysis |
|--|------------|----------------------|
| Infant Feeding Strategy 2019 (current refresh underway to 2025) | 31/12/2024 | Progressing |
| Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan | 31/03/2026 | Progressing |
| All Wales Weight Management Pathway 2021 | 31/03/2026 | Progressing |
| Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways) | 31/03/2026 | Progressing |
| Together for Mental Health Strategy (local / national) | 31/03/2026 | Progressing |
| Well North Wales targeted partner programmes | 31/03/2026 | Progressing |
| Health Board Annual Plan / 3 year milestones and associated activity | 31/03/2026 | Progressing |
| Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases | 31/03/2026 | Progressing |
| Immunisation Strategy 2023-2026 | 31/03/2026 | Progressing |



N.B. Inherent and Current score lines stacked as both are 20.

| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

The population health of North Wales is worsening and has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities through loss of involvement. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board ability to deliver excellent healthcare services meaning the Health Board purpose must retain clear focus on improving the health and wellbeing of the population

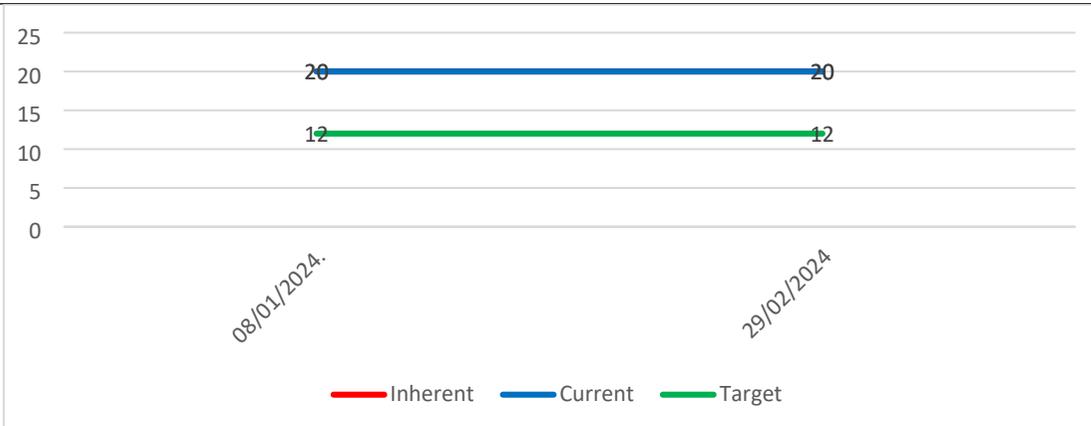
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|--|---|-------------------------|--|
| CRR 24-09 | Risk Title: Primary and Community Care services | | Date Opened: 08/02/2024 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: New Risk Due for review at PFIG 30/04/24 |
| Date Last Reviewed: 29/02/2024 | Director Lead: Executive Director of Operations (Executive Director Transformation And Strategic Planning) | Link to BAF: N/A | Target Risk Date: 31/03/2025 |

There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary and community care services. This may be due to challenges stem from various factors including staffing shortages, recruitment and retention issues, inadequate resources, limited prevention services, and funding constraints exacerbated by population growth and transient demographics. Moreover, deficiencies in strategic planning, data management, and information sharing further compound these challenges. The ramifications are wide-ranging, impacting the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This results in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|--|---|--|
| <ol style="list-style-type: none"> Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. Programme management implemented to monitor and drive strategic priorities. Primary Care Quality and Delivery Group established Q3 23/24 | 1st – eg. Local Assurances: <ol style="list-style-type: none"> Primary Care Quality and Delivery Group Primary Care Panel Risk Management Group Executive Team Meeting | <ol style="list-style-type: none"> Greater Health Board oversight of Primary Care issues and risks. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. Improved governance structures, process and procedures. Equity of resource to support primary care transformation, management and governance. |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> Quality, Safety and Experience Committee | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW WG performance monitoring and assurance Welsh Government Reviews | |

5. Royal College Reviews

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Primary Care Board established | 30/05/2024 | Progressing |
| Primary Care strategic plan | 31/03/2025 | Progressing |
| Escalation and sustainability implementation | 30/06/2024 | Progressing |
| Health Board Managed Practices – recommendations for improved governance report | 31/01/2024 | Completed |
| Focused on implementation of recommendations | 30/06/2024 | Progressing |



N.B. Inherent and Current score lines stacked as both are 20.

| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

Optometry reform delivery compromised, continue to have further managed practices and financial implications to the Health Board. Dental access compromised.

Recognition of inherent score currently further controls needed.

| | | | |
|--|--|-------------------------|---|
| CRR 24-10 | Risk Title: Urgent and Emergency Care | | Date Opened: 26/02/2024 |
| | Assuring Committee: Performance, Finance and Information Governance Committee | | Date Last Committee Review: New Due at PFIG 30/04/24 |
| Date Last Reviewed: 22/03/2024 | Director Lead: Executive Director of Operations (Executive Director Therapies & Health Science) | Link to BAF: N/A | Target Risk Date: 30/03/2025 |

There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This could impact on pressures for other services, reputation and litigation implications.

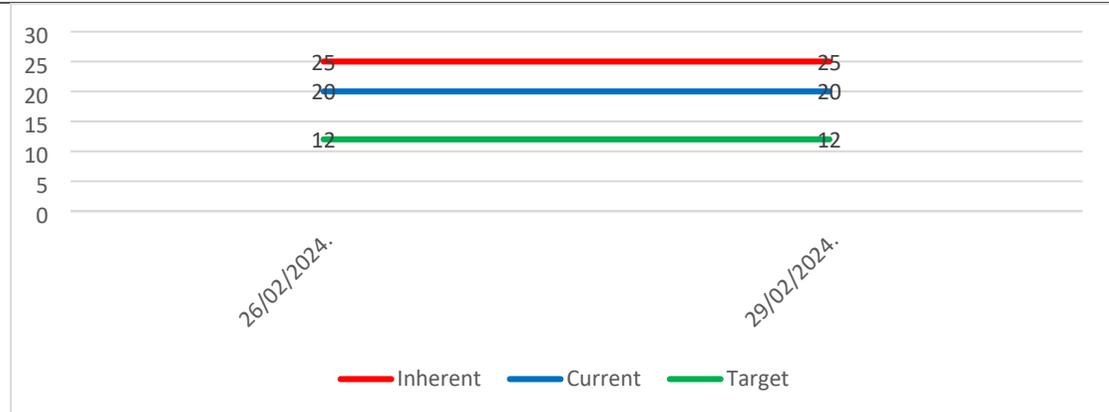
| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|--|---|--|
| <p>Daily management system in place to manage patient flow including multiple daily local and national calls.</p> <p>Continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos.</p> <p>Regular reviews of long stay patients in acute & community hospitals to reduce average length of stay.</p> <p>Training on discharge and complex care management is provided to ward based staff through the Complex Care and Unscheduled Care Team.</p> <p>System lead management 5/7 to have a singular point of escalation with external agencies and internal IHC concerns.</p> <p>Single Integrated Clinical Advice Triage (SICAT).</p> <p>Ambulance escalation process to support peak periods of demand.</p> <p>Hospital full protocols to support rapid de-escalation during peak periods of demand.</p> | <p>1st – eg. Local Assurances:</p> <ol style="list-style-type: none"> Operational Meetings ensure a Pan North Wales approach for managing daily UEC demand with external stakeholders Clinically optimised reviews across all IHCs take place on a regular basis with access into social care providers for support on getting patients care closer to home. IHC Management team led reviews with clear focus on action to support reducing LoS with a full multi-disciplinary team representation. Nurse led discharges being rolled out across North Wales to support timely discharges and utilisation of STREAM (IT System) to track planning. Senior operational managers managing daily demand across North Wales and being a singular point of escalation when Unplanned and Emergency Care (UEC) demand and capacity increases. Each Acute site has a process of internal escalation when delays occur with ambulance handovers occur with triggers for escalation and actions to be completed. Each IHC has a bed escalation process that supports triggers for escalation and gives triggers to support de-escalation in a timely fashion. | <ol style="list-style-type: none"> Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds. Delays in assessment of complex care cases and inefficient brokering resulting in increased delays and cost. Resources – System lead runs alongside staffs day to day roles and is extremely fragile in the current climate and requires either extending criteria of staff to support or development of the a permanent hub similar to that of IA. Funding spot purchasing of beds to assist with stepping up of patient care rather than hospital admissions. Vacant essential roles across BCUHB that will impact on patient care and operational |

| <p>Care Home risk and escalation plans to support care home capacity with community team's support.</p> <p>Winter Plan developed to manage whole system pressures. Urgent review of escalation options in development between health and social care to increase community care capacity and to reduce delays.</p> <p>Industrial action command and control structure in place to manage service impact and to minimise disruption to services. Winer plan reviewed and signed off by Executives/Board December 2023, with planning under way to commence resilience planning from April 2024 for season 2024/2025, planning is inclusive of local authorities and voluntary sectors to support a North Wales approach</p> <p>0800-2000hrs funded GP service working alongside WAST/111 to reduce ambulance responses and manage patients through alternative pathways reducing the need for ambulance attendances</p> <p>Monthly updates from WAST to confirm care home at risk for escalation, with regular reviews and training to support managing the patients care closer to home, this is further expanded by Immedicare (Remote advice) being in place across 15 care homes across North Wales.</p> <p>Increasing periods of industrial action occurring, IHCs planning continues along with weekly Silver and Gold reviews to ensure accurate communication with all stakeholders along with assurance for national agencies</p> | <p>2nd – eg. Board/Committee Assurances:</p> <p>1. Regular reporting to Performance, Finance and Information Governance Committee.</p> <p>3rd – eg. External Assurances:</p> <p>1. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW.</p> <p>2. WG performance monitoring and assurance</p> <p>3. Welsh Government Reviews</p> <p>4. Royal College Reviews</p> <p>5. Internal Audit</p> | <p>management resulting in inability to drive system change.</p> <p>6. Trusted assessors development, ongoing work for the last 18months, support required to progress at pace.</p> <p>7. Review of system lead/on call to support a 24/7 provision with an equal service provision. That amends the narrative from On call to shift focus.</p> <p>8. Winter resilience, earlier national feedback on any support available over the winter periods, in place of the November/December notification that does not allow maximum utilisation.</p> <p>9. Continuous flow modelling – National presentation on a model to decompress the Emergency department and create movement to reduce delays.</p> |
|---|---|--|
| Actions | Due Date | Progression Analysis |
| Transformational development of urgent care system (6 Goals) including developing 1000 beds and focus on ministerial priorities | 31/03/2024 | Progressing |
| Review of Complex Care arrangements in place to improve system improvements and to reduce delays | 30/04/2024 | Progressing |
| Industrial action (IA) management plans in place and require review for sustainability in light of on going planning for IA throughout 2024 | 30/04/2024 | Progressing |
| Urgent escalation plan in development to secure additional system impact to improve community care capacity and flow to be reviewed and amended from lessons learnt since implementation | 31/05/2024 | Progressing |
| BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 2024 | 30/06/2024 | Progressing |

Confirmation of national requirement for winter resilience plan going forwards or focus on a North Wales resilience plan for 2024-2025

31/08/2024

Progressing



| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

Regulations 28 (2020-2023)

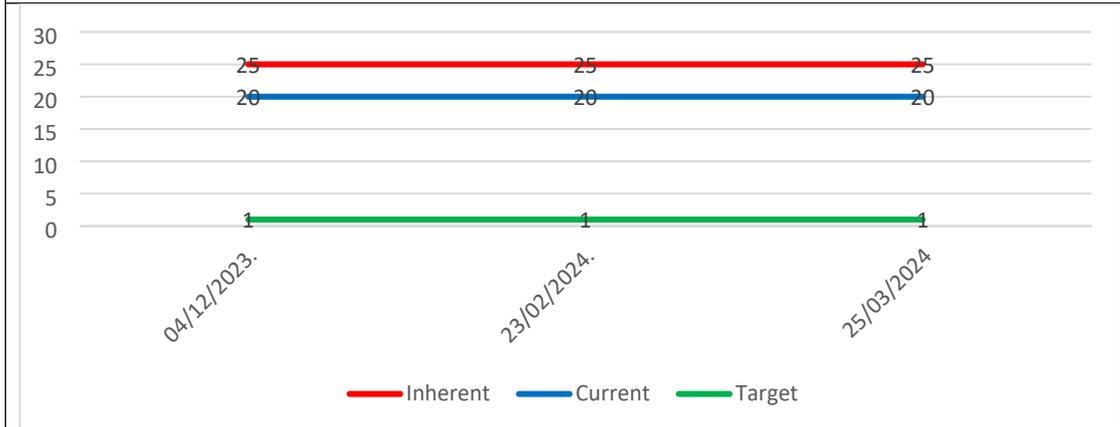
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|--|--|-------------------------|--|
| CRR 24-11 | Risk Title: Planned Care | | Date Opened: 04/12/2023 |
| | Assuring Committee: Performance, Finance and Information Governance Committee | | Date Last Committee Review: New Due for Review at PFIG 30/04/24 |
| Date Last Reviewed: 25/03/2024 | Director Lead: Executive Director of Operations (Executive Medical Director) | Link to BAF: N/A | Target Risk Date: 31/12/2024 (interim review) |

There is a risk of further deterioration in patients' health, **harm**, mortality or need for more complex treatment in relation to planned care services with a, resulting in failure to meet national access targets. This could be caused by **long waits and delays** for planned care, insufficient **capacity**, staffing shortages, increasing demand, and backlogs exacerbated by COVID. The impact would be worsening patient outcomes and experiences, increased complaints, financial penalties for target breaches, and reputational damage.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|--|
| <ol style="list-style-type: none"> Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer > Urgent > Routine) Performance monitored via weekly corporate access meeting and locally via IHC weekly access meetings including long waits and clinical prioritisation. Clinical prioritisation and review of waiting lists ongoing. Validating waiting list cohorts. | 1st – eg. Local Assurances: <ol style="list-style-type: none"> Routine operational performance monitoring (weekly corporate access meeting). Application of RTT guidance in maintaining and improving treat in turn rates Escalation to Planned Care Board Risk Management Group Executive Team | <ol style="list-style-type: none"> Capacity and demand modelling and trajectory tracking Development of sustainable service models to mitigate existing clinical risks Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access). The planned care funds available will mitigate the risks and will be closely monitored through the Planned Care Programme Board Chief Operating Officer vacancy. Refresh and renew INNU policy to ensure referrals are appropriate. |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> Performance, Finance and Information Governance Committee | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> Regulatory inspections and investigations – HSE, HIW, CIW, PSOW WG performance monitoring and assurance Welsh Government Reviews Royal College Reviews | |

5.Internal Audit

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Recruitment to the Llandudno/ Abergele business case (orthopaedic site). Funding not released, action overdue. | 31/03/2024 | Overdue |
| Approval of the application of sustainability funds and authority to deploy in line with Plan | 31/03/2024 | Overdue |
| Senior Responsible Officer for Planned Care Board | 31/03/2024 | Overdue |
| Recruiting to programmes of work in order to support successful delivery | 31/05/2024 | Progressing |
| Board Development session on planned care | 31/12/2024 | Progressing |



| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 1 | 1 | 1 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

RTT 52 week waits stage one - NHS Wales Performance Framework 2024-25 Target = 0. Current positions RTT 52 Stage 1 - 17,505 (although surgical West actuals are nearly 500 lower than the trajectory)

RTT 104 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0. Current positions RTT 104 all Stages -11,503 (9,435 over 104w +1,734 over 156w + 334 over 208w) To achieve this within 12 months would mean an additional 2,417 cases per month, at least 1,459 of which would be stage ones.

| | |
|--|---|
| | <p>RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to prioritise eliminating 156 or 208 weeks as early in the new financial year as possible.</p> |
|--|---|

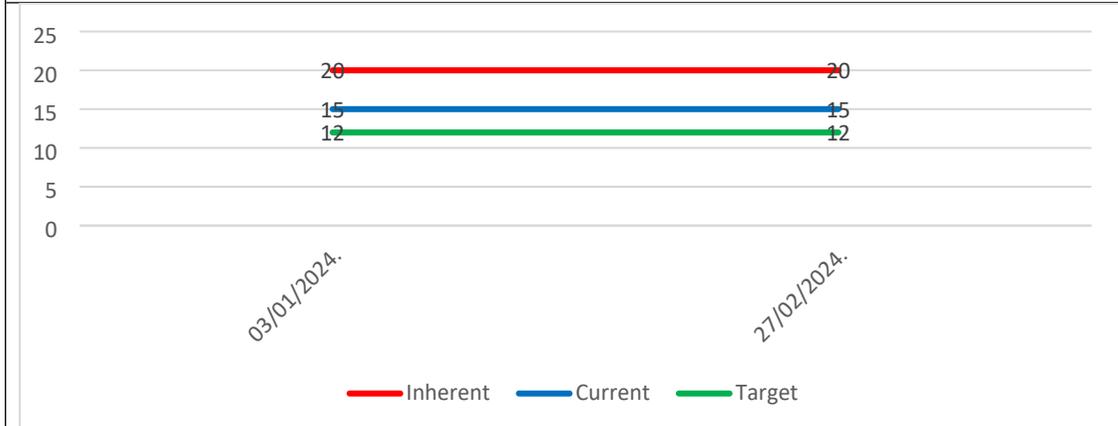
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|--|--|-------------------------|---|
| CRR 24-12 | Risk Title: Clinical Areas of Concern | | Date Opened: 15/12/2023 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/2024 |
| Date Last Reviewed: 25/03/2024 | Director Lead: Executive Medical Director/ Executive Director of Operations | Link to BAF: N/A | Target Risk Date: 01/03/2025 |

There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|--|--|
| <ol style="list-style-type: none"> Strategic Improvement Groups for the fragile clinical specialties. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. Improvement plans for fragile specialties for specialties with clinical leadership. Prioritising/triaging cases in specialties with backlog. | 1st – eg. Local Assurances: | <ol style="list-style-type: none"> Implement plans for integrated electronic patient records Dermatology, ophthalmology, urology continue to have clinical leadership gaps Address lack of consistent medical cover in some specialties. SLA for services provided by non-BCUHB organisations Development of clinical model/pathways for fragile specialties with limited leadership incorporating relevant GIRFT and College recommendations Clinical validation of waiting lists |
| | <ol style="list-style-type: none"> Special Measures meeting and assurances to committees on 90 day cycle Quality Delivery Group Risk Management Group Executive Team Meeting | |
| | 2nd – eg. Board/Committee Assurances: | |
| | Quality, Safety and Experience Committee / Performance, Finance Committee | |
| | 3rd – eg. External Assurances: | |
| <ol style="list-style-type: none"> Internal Audit National touch point meetings with NHS Executive colleagues | | |

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Engagement with National Procurement Processes (ie eye record system) and National Programmes (ie Robotics) | 01/07/2024 | Progressing |
| Ongoing recruitment for substantive medical leadership roles. | 01/01/2025 | Progressing |

| | | |
|--|------------|-------------|
| Recruitment efforts including substantive, locum and agency staff. | 01/01/2025 | Progressing |
| SLAs to be signed off through governance structures | 01/08/2024 | Progressing |
| Clinical pathway events | 30/07/2024 | Progressing |
| Non-clinical and clinical validation exercises | 30/07/2024 | Progressing |



| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 3 | 15 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

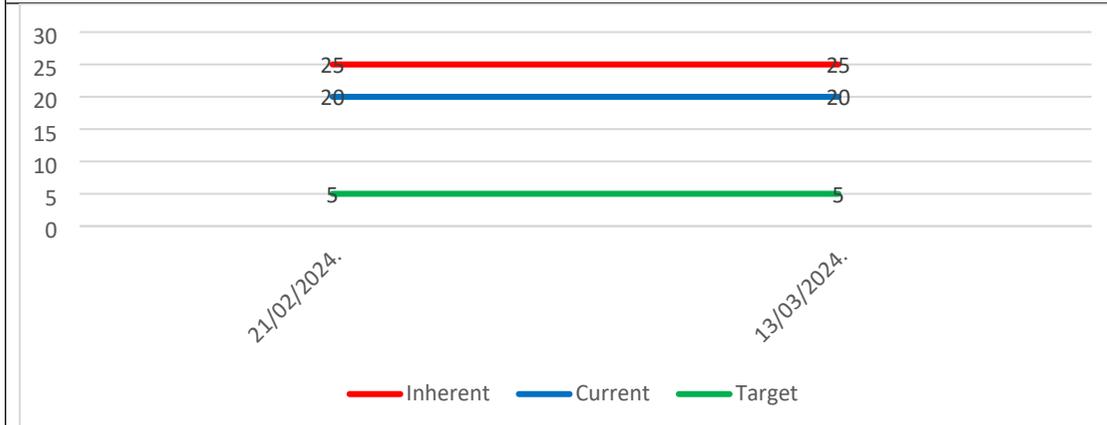
- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

| | | | |
|--|---|-------------------------|---|
| CRR 24-13 | Risk Title: Timely Diagnostics | | Date Opened: 21/02/2024 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/2024 |
| Date Last Reviewed: 13/03/2024 | Director Lead: Executive Director of Therapies & Healthcare Sciences | Link to BAF: N/A | Target Risk Date: 31/12/2025 |

There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|--|--|--|
| <ol style="list-style-type: none"> 1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc. 3. Significant guidance and steer with National Imaging Programme workforce work. 4. Outsourcing of radiology reporting to maintain welsh government turnaround times 5. Waiting list & capacity and demand management is in place to monitor radiology required resources. | 1st – eg. Local Assurances: <ol style="list-style-type: none"> 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. 2. Risk Management Group 3. Executive Team | <ol style="list-style-type: none"> 1. Replacement of Radiology Informatics System (RISP) – implementation underway 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements 4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – ‘Mitigation of the risk of failure to act on diagnostic results’ needs updating which is being led by the Executive medical director. 5. PHW Collaborative Executive group. 6. Diagnostic Strategy for BCU needs to be developed |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> 4. Quality, Safety and Experience Committee | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> 1. Internal Audit | |
| | <ol style="list-style-type: none"> 1. RISP being monitored via National and BCU implementation boards | |
| | | |

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024. | 14/04/2025 | Progressing |
| Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally | 30/09/2025 | Progressing |
| Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated | 31/12/2025 | Progressing |
| Radiology workforce revised model to be developed by June 2025 | 30/06/2025 | Progressing |
| Diagnostic Strategy to be developed by diagnostic group | 30/09/2024 | Progressing |



| | Impact | Likelihood | Score |
|----------------------|--------------|------------|----------|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 1 | 5 |
| Risk Appetite | Reputational | | 4 - Seek |

Rationale for Corporate Risk

Increasing demand for both radiology and pathology

Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues

Additional work required to mitigate the risks from failure to act and update procedure MD23

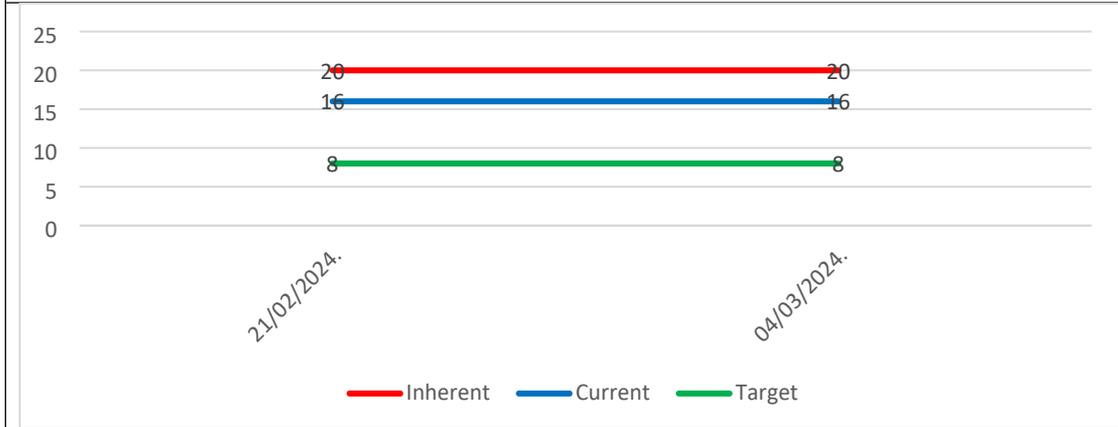
| | |
|--|--|
| | <p>Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.</p> |
|--|--|

| | | | |
|--|---|-------------------------|--|
| CRR 24-14 | Risk Title: Harm from the Medical Devices/Equipment | | Date Opened: 21/02/2024 |
| | Assuring Committee: Quality, Safety and Experience Committee | | Date Last Committee Review: 18/04/2024 |
| Date Last Reviewed: 04/03/2024 | Director Lead: Executive Director of Therapies & Healthcare Sciences | Link to BAF: N/A | Target Risk Date: 31/03/2024 (review point) |

There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|--|--|---|
| <ol style="list-style-type: none"> 1. Medical Devices Oversight Group leads on the capital investment and replacement plan. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed. | 1st – eg. Local Assurances: <ol style="list-style-type: none"> 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group 4. Risk Management Group 5. Executive Team Meeting | <ol style="list-style-type: none"> 1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. 2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 3. Lack of comprehensive governance structure around ensuring equipment all is safe and in line with regulations. 4. Lack of training around equipment and good governance of safety of equipment has been lacking and documented as a risk since 2016. 5. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement. 6. The number of bids not approved now reaching over millions in capital and resources required. Backlog of equipment beyond end of life, some 10 years+ |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> 6. Quality, Safety and Experience Committee | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> 1. Internal Audit 2. National Endoscopy and Diagnostic Programmes | |

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation | 31/03/2024 | Progressing |
| Review of internal and external group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate. | 31/02/2024 | Overdue |
| Medical physics have been tasked with testing all ultrasound equipment to ensure it's safety and will consider compliance | 31/03/2024 | Progressing |
| Review medical devices capital replacement to ensure all services have a medical devices replacement programme in place | 31/03/2024 | Progressing |
| Medical Devices strategy | 31/03/2024 | Progressing |
| Recruitment to medical devices team | 31/03/2024 | Progressing |



| | Impact | Likelihood | Score |
|----------------------|---------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 2 | 4 | 8 |
| Risk Appetite | Quality | | 3 - Open |

Rationale for Corporate Risk

Significant funding capital required, lack of robust controls and governance to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life.

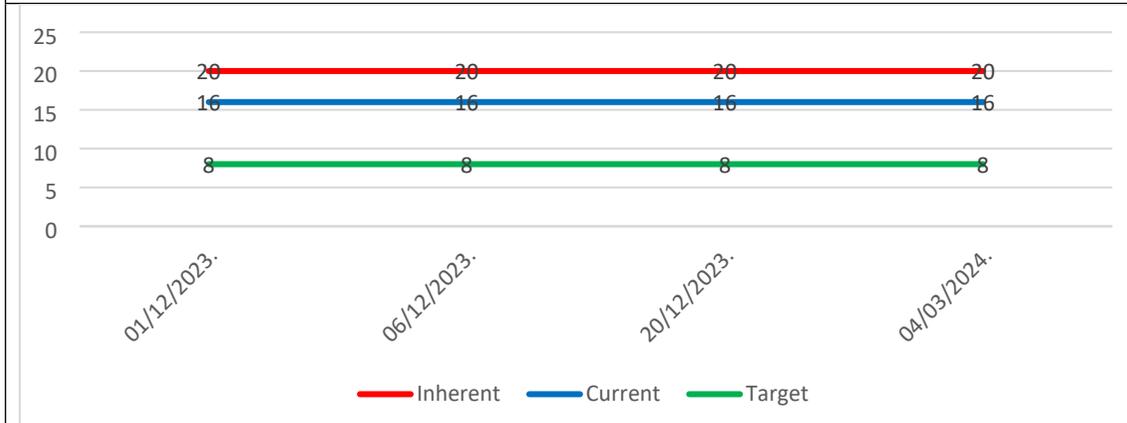
| | | | |
|--|---|-------------------------|--|
| CRR24-15 | Risk Title: Health and Safety | | Date Opened: 01/12/2023 |
| | Assuring Committee: People & Culture Committee | | Date Last Committee Review: 11/04/2024 |
| Date Last Reviewed: 04/03/2024 | Director Lead: Deputy Director of People | Link to BAF: N/A | Target Risk Date: 31/12/2024 |

There is a risk of avoidable harm to patients and staff. This is may be caused by a failure of the Health Board to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation due to the lack of Health and Safety Leadership. The impact is patient and staff harm, financial implications, and reputational impact to the Health Board.

| Mitigations/Controls in place | Lines of Assurances | Additional Controls required |
|---|---|---|
| <ol style="list-style-type: none"> 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. Further training commenced January 2024 with the NEBOSH General Certificate and NEBOSH Award. Policies and subgroups have been established including asbestos, water safety, fire electrical safety etc. to monitor and report into the Strategic Occupational Health & Safety Group. 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 Occupational Health, Safety and Security strategy in place that supports the Strategic Objectives of BCUHB. Falls are closely monitored by H&S advisors to review under RIDDOR reporting requirements | 1st – eg. Local Assurances: <ol style="list-style-type: none"> Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to People Committee Estates overseeing the high level risks as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire and report to the Strategic Occupational Health and Safety Group. | <ol style="list-style-type: none"> HS01 to be updated when the Executive portfolios have been finalised. This will go out of date in December 2023 and a six month extension has been requested. There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. New role of Director of Environment to be recruited to reporting to CEO, which will review Estate business cases Manual handling training compliance is currently at 68%. The team have moved back to the BCUHB sites as the two year contracts for external training venues have ended. The effects of these moves is not fully known yet. 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 resulting in prosecution. Lack of formal arrangements in place to protect premises and people in relation to CCTV, violence and aggression, Security |
| | 2nd – eg. Board/Committee Assurances: <ol style="list-style-type: none"> People & Culture Committee | |
| | 3rd – eg. External Assurances: <ol style="list-style-type: none"> Internal Audit RIDDOR reporting to the Health and Safety Executive in place with robust timeline. | |
| | | |

Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed

| Actions | Due Date | Progression Analysis |
|---|------------|----------------------|
| A clear strategy and framework | 31/12/2024 | Progressing |
| NEBOSH training courses to go forward for the General Certificate and the Award. | 31/12/2024 | Progressing |
| Business case for security provision approval process underway. | 31/12/2024 | Progressing |
| H&S not noted as a deliverable on the Annual Plan for priorities and Strategic Objectives are due to be reviewed. | 31/12/2024 | Progressing |



| | Impact | Likelihood | Score |
|----------------------|--------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 2 | 4 | 8 |
| Risk Appetite | People | | 4 - Seek |

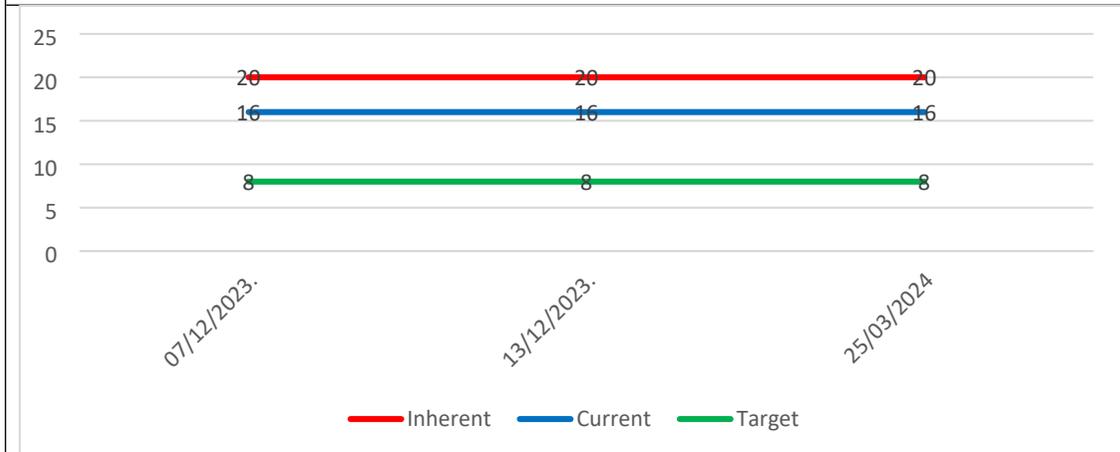
Rationale for Corporate Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training.

| | |
|--|--|
| | Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO. |
|--|--|

| CRR 24-16 | Risk Title: Leadership/Special Measures | | Date Opened: 07/12/2023 |
|---|--|-----------------------------|---|
| | Assuring Committee: People & Culture Committee | | Date Last Committee Review: 11/04/2024 |
| Date Last Reviewed: 25/04/2024 | Director Lead: Deputy Director of Workforce | Link to BAF: SP17 | Target Risk Date: 30/09/2024 |
| <p>There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.</p> | | | |
| Mitigations/Controls in place | Lines of Assurances | | Additional Controls required |
| <ol style="list-style-type: none"> 1. Board Workshop with Professor Michael West on compassionate leadership 2. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. 3. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 4. Full Board now in place and all committees now chaired and attended by full complement of Independent Members | 1st – eg. Local Assurances: | | <ol style="list-style-type: none"> 1. Integrated Leadership Development Framework 2. New approach to leadership and how to adopt it, aligned with the work on values and behaviours 3. Formal Culture Change Plan and accompanying Comms and Engagement plan 4. A Behaviours Framework 5. Fully resourced Culture Change programme |
| | <ol style="list-style-type: none"> 1. Organisational Development Steering Group 2. Local Integrated Health Communities & Pan Services People & Culture Committees 3. Risk Management Group 4. Executive Team Meeting | | |
| | 2nd – eg. Board/Committee Assurances: | | |
| | <ol style="list-style-type: none"> 1. People Committee to the Board and through the CEO report to the Board. | | |
| | 3rd – eg. External Assurances: | | |
| <ol style="list-style-type: none"> 1. Internal Audit 2. Welsh Government JET meetings | | | |
| Actions | | | Due Date |
| <p>Integrated Leadership Development Framework socialised across the organisation for feedback. Work has taken place on further co-design and to socialise the draft Integrated Leadership Development Framework (ILDF) across the organisation. This has involved members of the OD team</p> | | | 31/01/2024 |
| | | | Complete |

| | | |
|--|------------|------------|
| attending meetings already in place to share the proposed framework, inviting staff to feed back on the design and logo as well as the content of the framework. MS Teams virtual sessions (including evening and weekend sessions) have also been hosted inviting staff from across the organisation to attend and share their feedback and comments. Based on the feedback, amendments have been made, a recent copy of the draft ILDF can be found on BetsiNet. | | |
| Integrated Leadership Development Framework implementation plan presented to Executive Team. The ILDF is currently being updated following feedback from March's OD Steering group where it was presented. The revised ILDF will go to May's OD Steering group for agreement. | 29/02/2024 | Overdue |
| Exploration of approach to leadership: Draft proposal of the approach and how to adopt it presented via an appropriate Executive governance process. The Approach to Leadership is integral to the culture development work, the approach was agreed at the ODSG in March | 29/02/2024 | Complete |
| OD Steering Group established. To date, the OD Steering Group have met on two occasions - 05/02/2024 and 04/03/2024. | 30/12/2023 | Completed |
| Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) | TBC | New action |
| Draft OD plan in development (forms part of special measures monitoring) | TBC | New Action |
| Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan | TBC | New action |



| | Impact | Likelihood | Score |
|----------------------|------------|------------|----------|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | Regulatory | | 3 - Open |

| | |
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| | <p style="text-align: center;">Rationale for Corporate Risk</p> <p>Structures currently being embedded to ensure IHCs, Divisions and Services have clear accountable delivery plans so new ways of leading are embedded locally. Organisational expectations being defined.</p> |
|--|--|

| | |
|---|---|
| Teitl adroddiad: Report title: | Annual Conformance Report 2023/24 |
| Adrodd i: Report to: | Audit Committee |
| Dyddiad y Cyfarfod: Date of Meeting: | Tuesday, 07 May 2024 |
| Crynodeb Gweithredol: Executive Summary: | <p>This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations. The areas covered in this report are:</p> <ul style="list-style-type: none"> <p>• Purchase orders that are non-compliant with SFI's (April 2023 to March 2024)</p> <p>This data set relates to orders being raised after the invoice has been received.</p> <p>There has been a reduction in non-compliance, with 1,460 in Q1, 1,145 in Q2, 964 in Q3 and 707 in Q4. Year end is traditionally an outlier with 307 breaches in March 24 which is a material improvement compared to 489 in March 23. A significant proportion of the orders are for known expenditure such as Locum and Agency spend or Healthcare services; however, the variable nature of the volume means that retrospective orders are produced.</p> <p>Departments in which the breach arose, are reminded of the SFI requirements and are required to take action to ensure future breaches do not re-occur. Reminder bulletins on financial instructions are included in Procurement communications and these reiterate to staff that they must have approval before committing expenditure.</p> <p>• E-Waiver System Developments and Single Waivers (April 2023 to March 2024)</p> <p>Finance launched a new eWaiver system in February 2024, following a period of user testing which commenced in December 2023.</p> <p>There has been a significant decrease in the number of approved waivers during the year.</p> <p>Single Tenders – 10 approved in Q4, compared to 41 last year; 59 for the full year, compared to 147 last year.</p> <p>Single Quote – 4 approved in Q4, compared to 33 last year; 45 for the full year, compared to 85 last year.</p> <p>• Receivables and conformance with payroll procedures</p> <p>The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.</p> <p>As at 31st March 2024, there were 3,714 outstanding invoices, totalling £13.6m, of which 1,036 invoices, totalling £7.9m were less than 30 days old.</p> <p>The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments</p> |

| | |
|--|---|
| | <p>should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period.</p> <p>For the period April 2023 to March 2024 there were 482 staff overpayments, with a gross value of £1.216m, compared to 618 and £1.332m in the previous year. Failure to complete forms on time remains the main cause of overpayments (286 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.</p> <p>As at 31st March 2024 the balance outstanding was £1.235m, compared to £0.948m at 31st March 2023.</p> <ul style="list-style-type: none"> • Payables and conformance with Public Sector Payment Policy (PSPP) <p>The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The year-end position achievement for non-NHS invoices by number is 94.5%.</p> <ul style="list-style-type: none"> • Losses and special payments <p>Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).</p> <p>Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.</p> <p>Clinical negligence claims are managed by Legal and Risk Services and there were 310 active claims at the end of March 2024. Of these 121 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £155m (before reimbursement from the Welsh Risk Pool).</p> <ul style="list-style-type: none"> • Consequential Loss <p>In November 2023, the Audit Committee approved the consequential losses claims from Deeside Leisure Centre due to the closure of their facilities whilst being occupied by the Health Board as part of the Covid Pandemic Response. The final calculation of the consequential loss was £1,519.08 higher than the value provided to the Committee. The Welsh Government have approved the full and final losses claim.</p> |
| <p>Argymhellion:</p> <p>Recommendations:</p> | <p>The Audit Committee is asked to:</p> <ol style="list-style-type: none"> 1. To note and discuss the below elements of performance <ul style="list-style-type: none"> • Purchase orders that are non-compliant with SFI's • E-Waiver System Developments and Single Waivers • Receivables and conformance with payroll procedures • Payables and conformance with Public Sector Payment Policy (PSPP) 2. Approve the Losses and Special Payments (January to March 2024) 3. Approve Consequential Loss, £1,519.08 |
| <p>Arweinydd Gweithredol:</p> | <p>Russel Caldicott, Interim Executive Director of Finance</p> |

| | | | | |
|--|---|--|---|---|
| Executive Lead: | | | | |
| Awdur yr Adroddiad: Report Author: | Denise Roberts, Head of Capital, Business Improvement and Compliance Andrea J Hughes, Interim Finance Director – Operational | | | |
| Pwrpas yr adroddiad: Purpose of report: | I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/> | I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/> | Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/> | |
| Lefel sicrwydd: Assurance level: | Arwyddocaol <i>Significant</i> <input type="checkbox"/> | Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> | Rhannol <i>Partial</i> <input type="checkbox"/> | Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> |
| | Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i> | Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i> | Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i> | Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i> |
| <p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p>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:</p> <p>Significant improvements have been made within the No PO No Pay and Single Waiver areas. Overpayment of salaries remains an area requiring further focus to ensure line managers complete staff changes forms on a timely basis.</p> | | | | |
| Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s): | Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose. | | | |
| Goblygiadau rheoleiddio a lleol: Regulatory and legal implications: | Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively. | | | |
| 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? | Not applicable | | | |
| 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? | Not applicable | | | |
| Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. | | | |

| | |
|---|--|
| Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR) | |
| Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations | Management of financial risk of not achieving value for money. |
| Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith Workforce implications as a result of implementing the recommendations | None |
| Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori Feedback, response, and follow up summary following consultation | Not applicable |
| Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: (or links to the Corporate Risk Register) | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. |
| Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) Reason for submission of report to confidential board (where relevant) | Not applicable |
| Camau Nesaf: Gweithredu argymhellion Next Steps: Implementation of recommendations <ul style="list-style-type: none"> <i>The report is for noting and, in the case of losses and special payments, approval</i> | |
| Rhestr o Atodiadau: List of Appendices: <ol style="list-style-type: none"> Single Tender Waivers – January – March 2024 | |

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

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

| Contract Value(ex VAT) | Minimum Competition |
|---|---------------------------------------|
| <£5,000 | At discretion of appropriate Director |
| £5,000-£25,000 | 3 written quotations |
| £25,000-OJEU threshold | 4 tenders |
| Above OJEU threshold (currently £118,133) | 5 tenders |
| Contracts between £500k and £1 million | WG Ministerial Approval for noting * |
| Contracts above £1 million | WG Ministerial Approval required * |

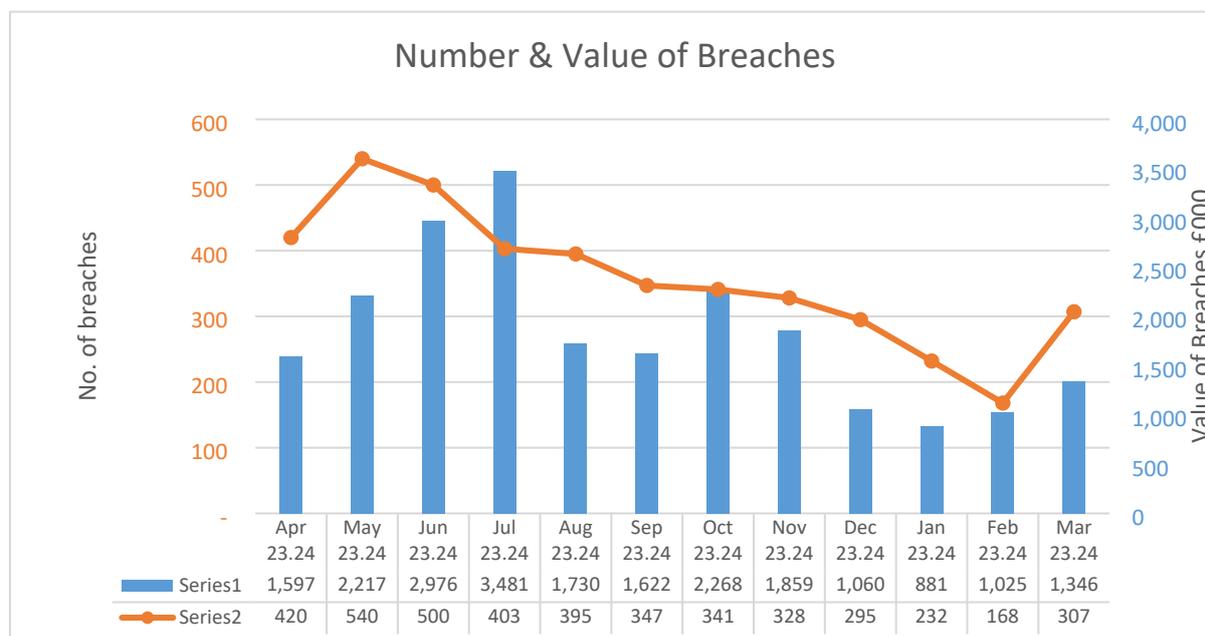
- Exemptions apply (see SFIs)

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

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows an improvement in breaches during the year, with 1,460 in Q1, 1,145 in Q2, 964 in Q3 and 707 in Q4. Year end is traditionally an outlier with 307 breaches in March 24 which is a material improvement compared to 489 in March 23. A significant proportion of the orders are for known expenditure such as Locum and Agency spend or Healthcare services; however, the variable nature of the volume means that orders are retrospective placed once final quantities are known.

The value and number of breaches between April 2023 and March 2024 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 3 highest value orders for the year are as follows:

| Division | Description | PO Amount £000s |
|-------------------|----------------------------------|--------------------|
| Central Area | Vaccines for GPs | 267 |
| Ysbyty Gwynedd | Endoscopy Insourcing | 258 |
| Regional Services | Provision of CT and MRI Services | 257 |

The Divisions with the highest number of PO breaches are listed below:

| Division | Q1 | Q2 | Q3 | Q4 | Total |
|------------------------------------|-----|-----|-----|-----|-------|
| Integrated Health Community East | 673 | 430 | 412 | 274 | 1789 |
| Integrated Health Community Centre | 300 | 299 | 228 | 154 | 981 |
| Integrated Health Community West | 270 | 183 | 136 | 90 | 679 |
| Regional Services | 165 | 71 | 127 | 66 | 429 |
| Mental Health & LDS | 131 | 88 | 79 | 98 | 396 |

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

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

c) E-Waiver Developments

Finance has launched new waiver system following a period of user testing in December 2023, which became live in February 2024.

The new waiver system facilitates key areas of improvement including compliance with delegated limits contained within the Scheme of Reservation and Delegation (SoRD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary; and improved reporting.

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

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

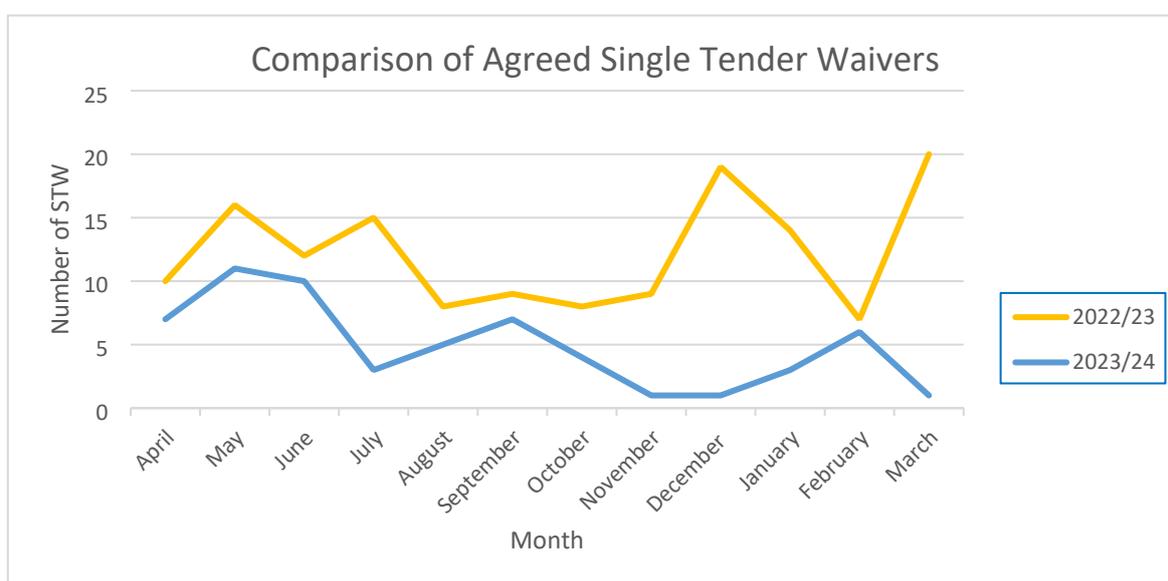
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause;
- A need to retain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

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

| Single Tender Waivers | 2023/24 Q1 to 3 | 2023/2024 Q4 | 2023/24 Full Year | Q4 2022/23 | 2022/23 Full Year |
|-------------------------------------|--------------------|-----------------|----------------------|---------------|-------------------------|
| Waivers Issued | 74 | 26 | 100 | 59 | 167 |
| Waivers Approved | 49 | 10 | 59 | 41 | 147 |
| Value of Approved Waivers | £3.9m | £0.6m | £4.5m | £2.4m | £9.1m |
| Waivers approval above EU Threshold | 8 | 0 | 8 | 5 | 18 |
| Cancelled Waivers | 11 | 2 | 13 | 1 | 8 |

The number of approved waivers has significantly reduced during the year.

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



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

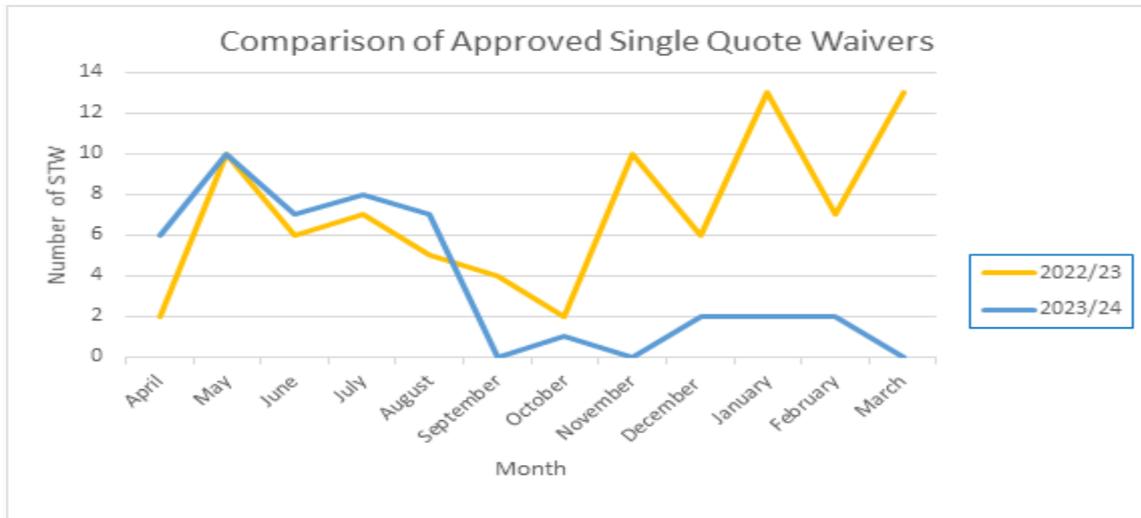
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

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

| Single Quote Waivers | 2023/24 Q1 to 3 | 2023/2024 Q4 | 2023/24 Full Year | Q4 2022/23 | 2022/23 Full Year |
|---------------------------|--------------------|-----------------|----------------------|---------------|-------------------------|
| Waivers Issued | 73 | 21 | 94 | 40 | 156 |
| Waivers Approved | 41 | 4 | 45 | 33 | 85 |
| Value of Approved Waivers | £0.5m | £0.05m | £0.55m | £0.5m | £1.1m |
| Cancelled Waivers | 10 | 0 | 10 | 1 | 2 |

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

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



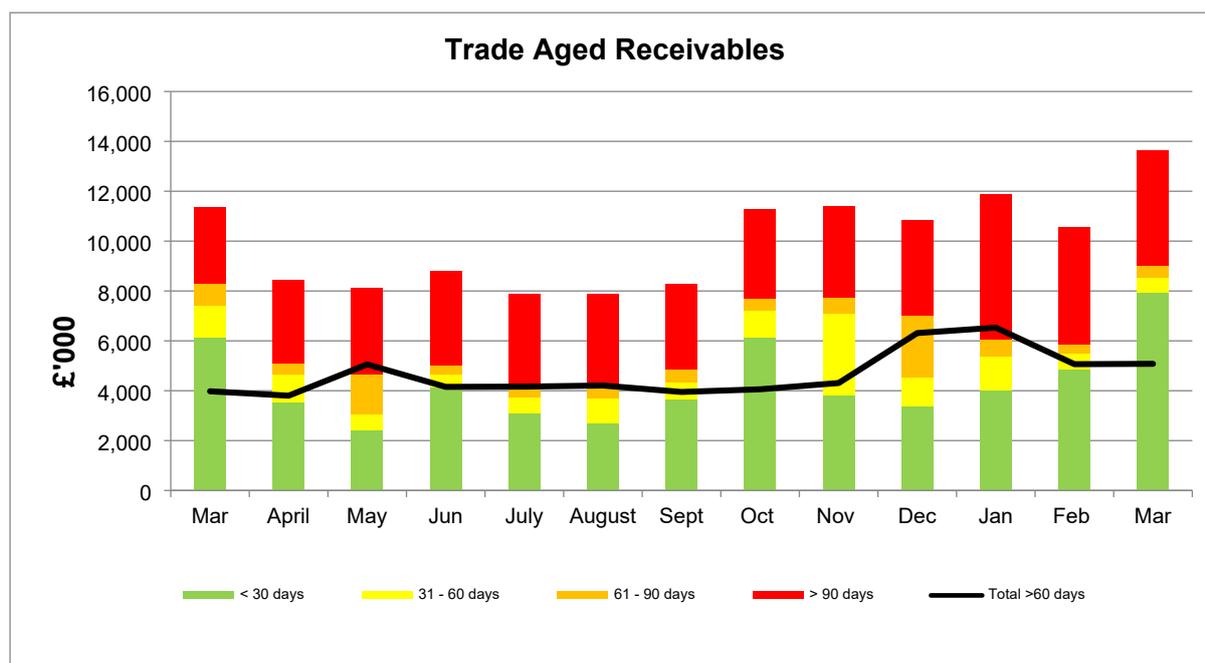
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

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

As at 31st March 2024, there were 3,714 outstanding invoices, totalling £13.6m, of which 1036 invoices, totalling £7.9m were less than 30 days old.

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



Provisions for bad and doubtful debts

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

Receivable balances over £10,000 and in excess of 6 months old as at 31st March 2024

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

| Customer | £000's | Number of invoices | Analysis and further action | Date debt raised |
|--|--------|--------------------|---|------------------|
| St David's Hospice | 457 | 7 | Invoices relate to capital works completed at Ysbyty Penrhos Stanley prior to the Covid-19 pandemic. Whilst the Health Board agreed a re-payment profile with St David's Hospice in October 2022 which would protect the Hospice's cash flow and allow the debt to be repaid in full over 4 years, no payments have yet been received. Discussions ongoing. | Dec 19 – Mar 22 |
| St Helens & Knowsley Hospitals NHS Trust (now Mersey and West Lancashire Teaching Hospitals NHS Trust) | 176 | 3 | Recharge of specialist registrar rotation. Query regarding funding for placement, customer states they should not have been recharged. Ongoing discussions, last meeting to resolve took place in April 2024. | Sep 22 - Mar 23 |
| NHS Cheshire and Merseyside ICB | 133 | 1 | Recharge for LAC placements, charges relate to various CCG's therefore there are delays as multiple approvals are required. Last statement sent March 24. Followed up 22/4/24 and contact is again chasing service leads. | Jan23 |
| The Walton Centre | 112 | 5 | Charge for radiology testing, a part credit has been raised, awaiting response if invoices will now be paid. Last statement sent March 24, chasing contacts. | Apr 22 & Sep 23 |
| Liverpool University Hospital NHS Foundation Trust | 100 | 1 | Recharge for specialist placement, a query has been raised which has been referred back to the IHC team to respond. Last meeting took place mid April 24. | Aug-23 |
| Overseas Patient | 59 | 2 | Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment | Jul 22 & Sep 22 |
| Salary Overpayment | 38 | 2 | Overpayments have been referred to Workforce & Organisational Development who are liaising with the debtor. Followed up with WOD 22/4/24. | Feb 22 & Apr 23 |
| Sun Pharma UK Ltd | 33 | 2 | Off contract claim for drugs. Limited response from chasing emails, backing was sent again at the beginning of April 24 along with copy invoices, next step would be CCI end of April. | Aug-23 |
| Salary Overpayment | 26 | 1 | The payroll department are investigating the overpayment, as the calculation could potentially be incorrect and a credit may be required. Followed up with WOD 22/4/24. | July-23 |
| NHS South West London ICB | 22 | 1 | Recharge for non-contracted activity, query has been raised by customer as they believe the charges have been duplicated. Clarified not a duplicate – Chased again June 23 and April 24. | Jan-23 |
| Overseas Patient | 20 | 1 | Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment | Aug-22 |
| Denbighshire County Council | 20 | 1 | Recharge for transformation grant £20,000. Council have disputed liability and this is now being dealt with by the Central IHC Finance Team. | Mar-20 |

| | | | | |
|---------------------------------------|----|---|---|--------|
| Salary Overpayment | 20 | 1 | The employee repaid an initial £8,000 against this salary overpayment and agreed to set up a repayment plan for the remaining balance. As the initial instalment was never received the invoice was referred to a debt collection agency for further action. The debtor has made an offer to repay the remaining balance over seven years which has been rejected and contact has been made to request an increase in the offer. This invoice remains with CCI, the debtor has been taken to court and has a CCJ for the debt along with interest and legal costs. BCU agreed to a revised repayment amount of £2,000 per month however no payments received as yet – in hands of solicitor at CCI, | Mar-20 |
| Pfizer Ltd | 20 | 1 | Recharge for high cost drugs. Pfizer have refused to pay as no PO was quoted on the invoice, the invoice has been referred to the Health Board's debt collection agency who are liaising with Pfizer's solicitors. A settlement has been reached 9/4/24, payment should follow shortly. | Mar-21 |
| NHS North East & North Cumbria ICB | 19 | 1 | Recharge for non-contracted activity. A part credit has been raised and payment is now awaited. | Feb-23 |
| Salary Overpayment | 17 | 1 | Payroll have recently re-calculated the overpayment and a credit has been raised and sent to the debtor, a response is now awaited to confirm if the overpayment figure is now agreed. | Nov-21 |
| NHS Cambridgeshire & Peterborough ICB | 17 | 1 | Recharge for non-contracted activity. A part credit has been raised and payment is now awaited. March 24 - requested a copy of the credit note which was emailed the same day, this invoice should now be approved for payment | Sep-23 |
| Private Patient | 16 | 1 | Charge for inpatient treatment, the invoice has been referred to the patient's insurance company. | Jun-22 |
| Salary Overpayment | 14 | 1 | Debtor has not responded despite numerous letters and reminders, if no response is received, the debt will be referred to a debt collection agency by end of April. | Jan-22 |
| Salary Overpayment | 12 | 1 | Debtor has not responded to numerous chasing therefore the debt has been referred to a debt collection agency. The Health Board has now been advised that the debtor has entered into an Individual Voluntary Arrangement (IVA) and full recovery will be unlikely. Expected to be on write off schedule in May 24. | Sep-21 |
| Salary Overpayment | 11 | 1 | Discussions are ongoing with the debtor who states they were not aware they were being overpaid at the time they received the salary. Certain benefits have been withdrawn due to the overpayment therefore talks are on-going. | Feb-23 |
| Salary Overpayment | 11 | 1 | The debtor has not responded despite numerous letters and reminders and the debt has been referred to a debt collection agency who are trying to trace the debtor. | Nov-22 |
| Private Patient | 10 | 1 | Charge for chemotherapy drugs. The patient's insurance company have been contacted again and asked to make payment as a matter of urgency. There is a possible duplication of charges and a response is awaited from the income team. Last correspondence sent March 24, not a duplication there was an incorrect date noted on the invoice, insurance company were made aware of this. | Oct-20 |

| | | | | |
|--------------------|----|---|---|--------|
| Salary Overpayment | 10 | 1 | An initial repayment plan that was agreed by Workforce and Organisation Development has ceased and the debt is therefore being referred back to WOD. The employee has now left BCU, awaiting confirmation that the invoice can be referred to a debt collection agency. No response to letters sent, will be on next CCI report (April). | Mar-23 |
|--------------------|----|---|---|--------|

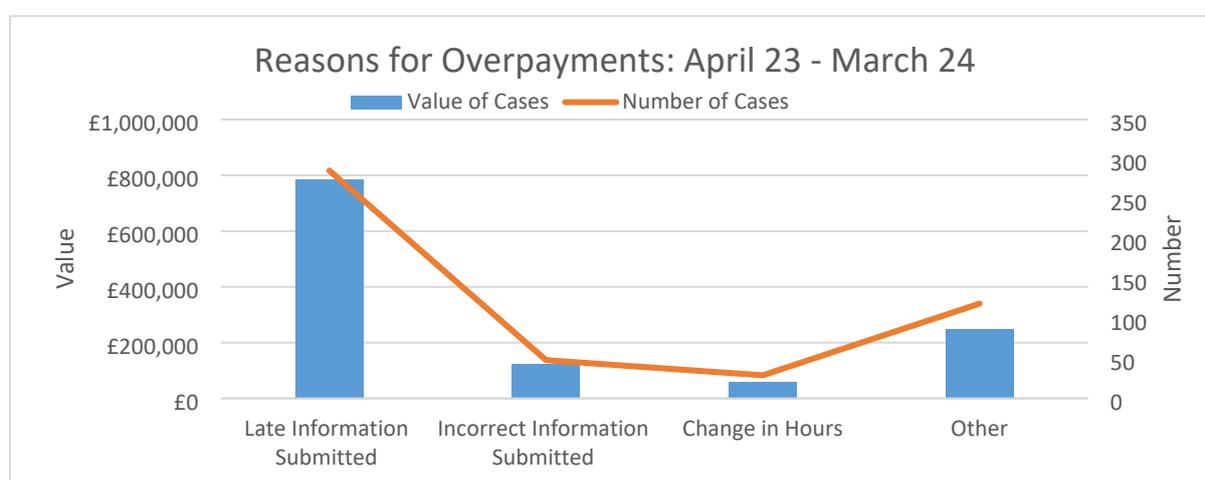
b) Staff Overpayments

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

| | 2022/23 Q4 | 2022/23 Full Year | 2023/24 Q4 | 2023/24 Full Year |
|--------------------------------------|---------------|----------------------|---------------|----------------------|
| Number of Salary Overpayments | 109 | 618 | 127 | 482 |
| Value of Salary Overpayments | £0.352m | £1.332m | £0.307m | £1.216m |

For the period April 2023 to March 2024 there were 482 staff overpayments, with a gross value of £1.216m, compared to 618 and £1.332m in the previous year.

Failure to complete forms on time remains the main cause of overpayments (286 cases). The reasons for the overpayments are detailed below.



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

Staff Overpayment Repayments

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

As at 31st March 2024 the balance outstanding was £1.235m (31st March 2023 £0.948m). The debt, by collection stage, is detailed below:

| | No. of Cases | % of Total Outstanding | Value of Total Outstanding |
|-----------------------------------|--------------|------------------------|----------------------------|
| Agreed Instalment Plans | 231 | 33% | £0.324m |
| Collection Agents | 227 | 33% | £0.361m |
| In Dispute or Under Review | 153 | 22% | £0.396m |
| Reminder Stage | 31 | 4% | £0.860m |
| Invoice Stage | 49 | 7% | £0.690m |

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

The extremely aged debts are there because either:

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

Section 3 - Conformance with Losses and Special Payments Procedures

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

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

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 310 active claims at the end of March 2024. Of these 121 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £155m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

61% of the caseload (189 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

| Year claim registered | No of claims |
|-----------------------|--------------|
| 2023/24 | 63 |
| 2022/23 | 50 |
| 2021/22 | 52 |
| 2020/21 | 52 |
| 2019/20 | 45 |
| 2018/19 | 21 |
| 2017/18 | 7 |
| 2016/17 | 5 |
| 2015/16 | 4 |
| 2014/15 | 3 |
| 2013/14 | 1 |
| 2011/12 | 3 |
| 2010/11 | 1 |
| 2009/10 | 2 |
| 2008/09 | 1 |
| Total claims | 310 |

Losses and Special Payments

| | Q1 23/24 | Q2 23/24 | Q3 23/24 | Q4 23/24 | Latest quarter analysis and further action |
|--|----------------|----------------|----------------|----------------|--|
| | £ | £ | £ | £ | |
| Medical Negligence | | | | | |
| Gross cost | 6,304,445 | 3,352,279 | 6,256,148 | 9,541,733 | Payments were made on 145 cases, of which 26 came under the Redress Scheme. Damages were paid on 3 claims over £1m during Q4. |
| WRPS Reclaim | (5,823,346) | (3,008,695) | (5,697,060) | (9,150,159) | |
| Net Cost | 481,099 | 343,584 | 568,088 | 390,888 | |
| Personal Injury | | | | | |
| Gross cost | 97,010 | 98,142 | 140,383 | 77,848 | Payments were made on 65 cases. |
| WRPS Reclaim | (25,608) | (0) | (31,375) | (16,306) | |
| Net cost | 74,402 | 98,142 | 109,008 | 61,541 | |
| Loss of cash | 1,000 | 0 | 570 | 0 | No losses were reported in Q4. |
| Debtors written off | 376 | 7430 | 0 | 15,009 | Debtors are only written off as a last resort, after all means of collection have been exhausted. |
| Loss or damage to equipment, property and stock | 33,989 | 66,263 | 48,881 | 104,529 | Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. Pharmacy losses for 2 areas are reported in Q4 for the full financial year. |
| Ex-gratia payments | 19,154 | 23,076 | 17,437 | 19,259 | Relates to 14 payments for loss/damage of patient's property and 11 ombudsman payments for delayed and unsatisfactory treatment. |
| VERS Payments | 0 | 0 | 59,295 | 8,775 | All payments are approved by the RATS Committee. |
| Total | 607,020 | 538,495 | 803,279 | 600,001 | |

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

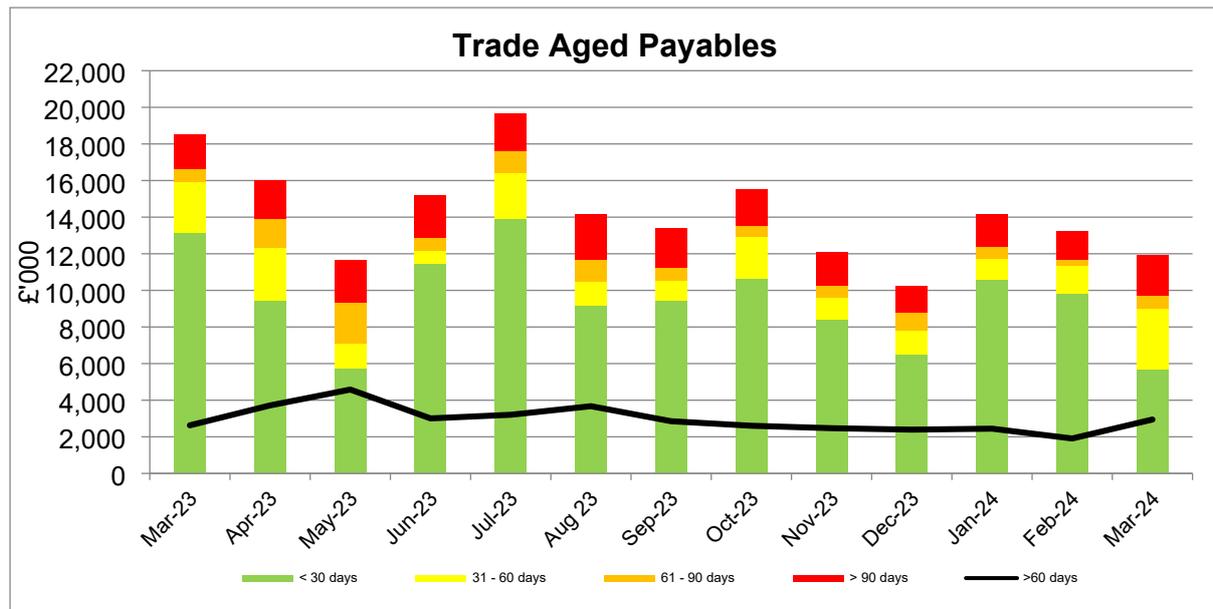
Section 4 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The 2023/24 achievement for non-NHS invoices by number is 94.5%.

High Value (£10,000 plus) Exceptions

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



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

Payable balances over 6 months old and over £10,000 as at 31st March 2024

| Supplier | £000's | No of Invoices | Analysis and further action | Invoice Date |
|-------------------------------|--------|----------------|---|-----------------|
| Omnicell Ltd | 103 | 2 | Price queries raised with supplier, awaiting response. | Mar 22 & Jun 22 |
| Flintshire County Council | 48 | 3 | Recharge for social workers - no names provided requested additional details awaiting response. Last comms via Teams on 27.03.24 refreshed list being shared due to their long-term absence) | Sep 23 |
| Johnson & Johnson Medical Ltd | 24 | 1 | Query over duplicate charges, awaiting company to respond. | Dec 22 |
| Medtronic Ltd | 16 | 1 | Supplier has been chased for a valid PO number as PO quoted is incorrect. | Mar 23 |
| Becton Dickson UK Ltd | 12 | 1 | Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. | Sep 22 |
| GN Hearing | 11 | 1 | Query raised with supplier as requisitioner has stated some items have been billed under a different invoice. Last comms 27.03.24 (via email) – scheduled meeting with supplier was postponed due to staff absence – look to re-arrange (not specific to this invoice, but multiple ongoing issues with supplier) | Nov 22 |

Appendix 1 - Approved Single Tender Waivers >£25K between 1st January – 31st March 2024

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value | Procurement Advice | Breached OJEU |
|----------------|----------------------------|---------------------------------|------------------|--|------------------------|------------|---|---------------|
| | | | | | | £000s | | |
| 2023/2024-1367 | 04/02/2024 | IHC West (Secondary Care - YG) | Zimmer Biomet | Robotic unit for knee replacements. Leased to the health board over 4 years. No monthly/annual lease cost providing payment for maintenance contract and over all spend above agreed amount. Robotic unit is compatible with the knee implants currently in use. | Maintenance | £86,850.00 | BCU are now utilising the continuation of the ROSA within YG, Zimmer Biomet are the manufacturer but sadly not included on NHSSC's Maintenance Framework. The maintenance for Year 1 is FOC, then for years 2, 3 and 4 is £28950 per annum. Staff are trained for use on the current equipment, impact to delivery of waiting lists if this application was unsuccessful. | No |
| 2023/2024-1382 | 09/02/2024 | IHC East (Secondary Care - YWM) | Inomed | Fluobeam - used for detecting parathyroid during surgery | Genuinely one provider | £34,768.68 | Procurement support this waiver on the basis that this is the sole provider for this specialist piece of equipment, the equipment is essential in reducing patient waiting lists whilst the Health Board explore the option of charitable funding to purchase their own machine at which point leasing would cease. | No |

| | | | | | | | | |
|----------------|------------|---|--------------------|---|-----------------------------------|-------------|---|----|
| 2023/2024-1389 | 31/01/2024 | Secondary Care - Managed Clinical Support | Hologic Ltd | 4-year service contract to follow on from warranty cover for 09/01/2025- 08/01/2029 (fixing price for 4 years) including one preventative maintenance service every 24 months post installation date. | Maintenance | £34,960.00 | Hologic are the OEM and the only provider that have the necessary knowledge, skills & expertise and spare parts to maintain their own equipment. Thus, supporting this Waiver request - JP, Category Manager, Maintenance Team | No |
| 2023/2024-1390 | 26/01/2024 | Secondary Care - Managed Clinical Support | Bausch + Lomb | Stellaris PC Elite with Laser and Stellaris Elite Comprehensive Service Support Agreement for comprehensive cover to ensure these units are safe to use. The period is 3 years to fix the cost. EBME cannot maintain these units. | Maintenance | £37,422.00 | Bausch & Lomb (UK) Ltd are the Original Equipment Manufacturer and the only provider that have the necessary skills, expertise and spare parts to maintain their own equipment and thus am supporting the Waiver request. JP, Category Manager, Maintenance Team | No |
| 2023/2024-1393 | 29/01/2024 | Capital | SP Energy Networks | Electrical Supply Upgrade | Genuinely one provider | £138,342.20 | Procurement Services support the use of a Single Tender Waiver on this occasion due to the Sole Supplier nature of this requirement. Scottish Power are the sole supplier of power within the Geographical Location of this project and therefore, the market cannot be approached. SH, Procurement Team 29/01/2024 | No |
| 2023/2024-1395 | 28/02/2024 | Corporate | AccuRx | It is no longer a free service from AccuRx and will be chargeable from early 2024, at 22p per patient on the practices list size. As this | Follow-up work from previous open | £125,140.00 | Procurement supports this waiver on the basis that this is an embedded software currently contracted through the G Cloud 13 framework however the added module | No |

| | | | | | | | | |
|----------------|------------|---|--------------|--|--|------------|--|----|
| | | | | <p>functionality was previously free of charge when the G-Cloud contract work was undertaken, it was not included in the original service specific.</p> <p>In order to retain the functionality, we are now in a position whereby a new contract or change of contract is required. The procurement team have advised a single tender waiver would be the preferred and most suitable option in this case.</p> | competition procurement | | <p>required is not a requirement available via the framework and therefore could not be added in as a contract variation. No other provider would be capable of providing this module as the main software will be different to their own. As the value exceeds the OJEU threshold Procurement advise that a Voluntary Ex-Ante Transparency Notice will also be required to be published advising the market of the Health Boards intent to contract with no competitive process prior to any commitment or purchase order being made to the provider.</p> | |
| 2023/2024-1397 | 01/02/2024 | Capital | TRON MEDICAL | 2 x Replacement Gamma Probes for Breast Surgery | Genuinely one provider | £58,147.00 | <p>Procurement supports this request as Tron Medical are the sole supplier of this Gamma Probe system which needs to purchased out of this years' capital spend,</p> <p>Contacted NHSSC/HTE to find a compliant Framework, this supplier is not available to purchase from via this route.</p> <p>As had confirmation that this type of Probe System is the only one on the market, the single tender waiver is the only option.</p> | No |
| 2023/2024-1403 | 26/02/2024 | Secondary Care - Managed Clinical Support | Haemonetics | <p>Renewal of licence and maintenance support for blood dispensing hardware and software interfaces.</p> <p>No other option to procure as required compatibility with LIMS and LIMS 2.0 interfaces and existing hardware.</p> | Compatibility Issue (e.g. warranty cover clause or specific equipment) | £63,616.35 | <p>Procurement support this ewaiver on the basis of compatibility with the future All Wales LIMS System. There is no available public sector framework for this product and therefore, in order to ensure that there is a transfusion system in place to align with LIMS go live dates there is no other option than to approve an ewaiver</p> | No |

| | | | | | | | | |
|----------------|------------|---|---------------------------------|---|------------------------|------------|---|----|
| 2023/2024-1409 | 08/03/2024 | Secondary Care - Managed Clinical Support | Ibex Medical Analytics | Software to allow analysis of digitised images of slides for prostate pathology | Genuinely one provider | £30,000.00 | Procurement support the use of a single tender waiver in this instance as the software is already in use across all of the Health Boards and is well established. The supplier do not provide the software via any Public Sector Frameworks therefore for the 12 month interim period for which funding has been received it is the best course of action to utilise an STA to allow BCU to continue demonstrating the benefits whilst a longer term funding route is explored. -RE - Assistant Head of National Sourcing - Clinical - 11/03/2024 | No |
| 2023/2024-1410 | 26/02/2024 | Secondary Care - Managed Clinical Support | Leica Microsystems (UK) Limited | 3 Year Premium Care Contract | Genuinely one provider | £22,854.00 | This is specialist equipment with only the manufacturer approved to maintain/service the equipment. MJ, Maintenance Team | No |



| | | | | |
|--|---|---|---|---|
| Teitl adroddiad: <i>Report title:</i> | Internal Audit Progress Report 1 March to 18 April 2024 | | | |
| Adrodd i: <i>Report to:</i> | Audit Committee | | | |
| Dyddiad y Cyfarfod: <i>Date of Meeting:</i> | 7 May 2024 | | | |
| Crynodeb Gweithredol: <i>Executive Summary:</i> | <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none"> the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. <p>The progress report summarises three assurance reviews finalised since the last Committee meeting in January 2024, with the recorded assurance as follows:</p> <ul style="list-style-type: none"> Substantial assurance (green) – none; Reasonable assurance (yellow) – none; Limited assurance (amber) – one; Unsatisfactory (red) – none; and Advisory/Assurance not applicable (grey) – two. <p>The report also details the reviews with reports issued as draft and work in progress.</p> | | | |
| Argymhellion: <i>Recommendations:</i> | <p>The Committee is asked to:</p> <ul style="list-style-type: none"> Receive the progress report. Approve deferment of the Contracted patient services: Quality and safety arrangements (Follow up). | | | |
| Arweinydd Gweithredol: <i>Executive Lead:</i> | Director of Corporate Governance | | | |
| Awdur yr Adroddiad: <i>Report Author:</i> | Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA | | | |
| Pwrpas yr adroddiad: <i>Purpose of report:</i> | I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/> | I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/> | Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/> | |
| Lefel sicrwydd: <i>Assurance level:</i> | <p>Arwyddocaol <i>Significant</i> <input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p> | <p>Derbyniol <i>Acceptable</i> <input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Rhannol <i>Partial</i> <input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p> | <p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p> |
| Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: | | | | |

| | |
|--|--|
| 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. 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. |
| 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 Director of Corporate Governance and Executive Team. |
| Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) | N/A other than those relating to individual audit reviews. |

| | |
|---|-----|
| Links to BAF risks: <i>(or links to the Corporate Risk Register)</i> | |
| 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 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: <ul style="list-style-type: none"> • Appendix 1: Progress report • Appendix 2: Special Measures – Contract and Procurement Review • Appendix 3: Deprivation of Liberty Safeguards | |

Betsi Cadwaladr University Local Health Board

Audit Committee Internal Audit Progress Report

1st March to 18th April 2024

NWSSP Audit and Assurance Services

Contents

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| Delivering the Plan | 9 |



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice - please note:

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

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

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

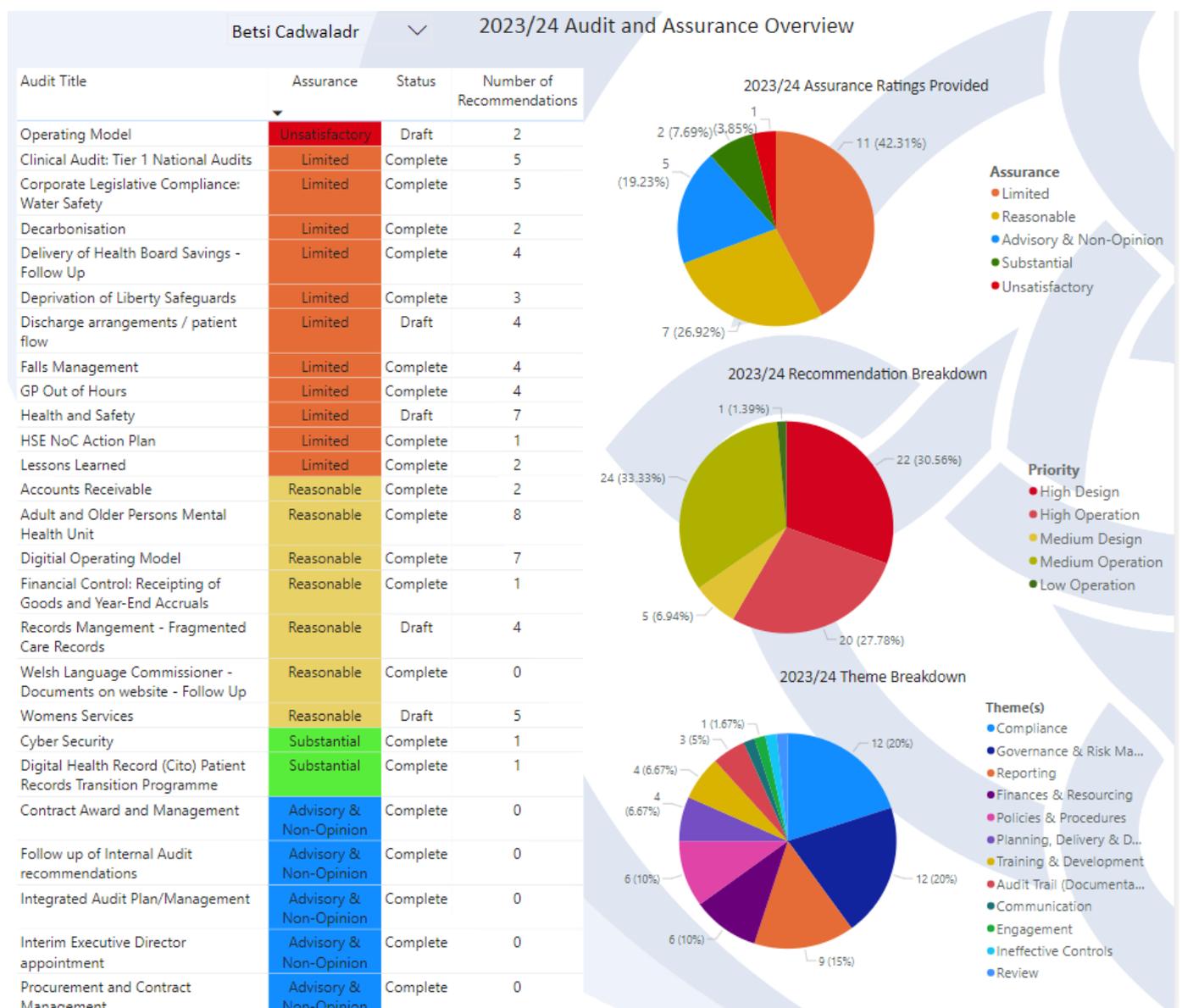
Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2023-24.

Reports Issued

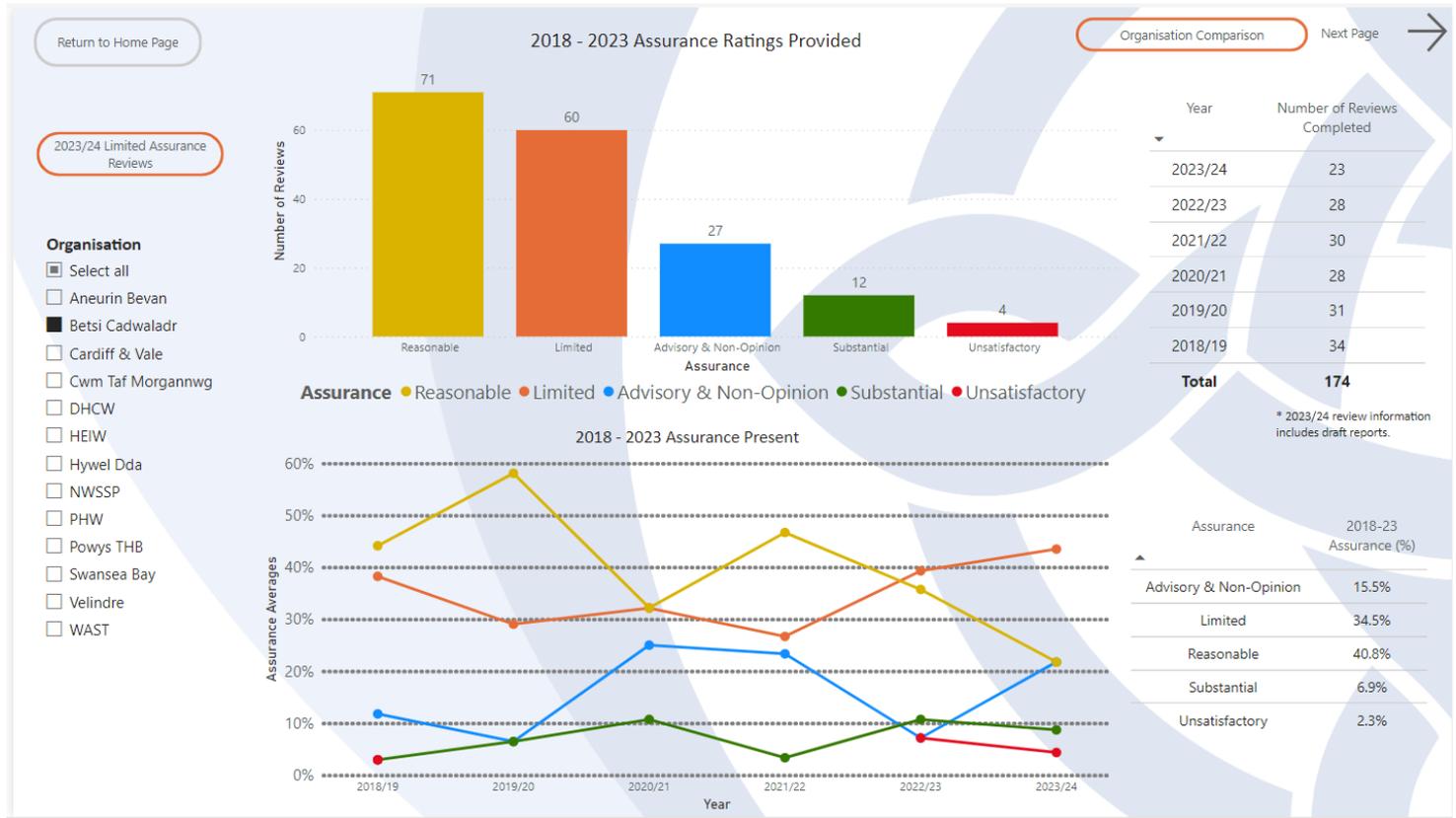
2. Since the last progress report, three reviews have been finalised, and four issued as draft. Executive summaries of the finalised reviews is provided below.
3. In reviewing the 2023/24 draft and final reports issued to date, image 1 details the high-level information from the reviews. This shows the key themes of recommendations relate to compliance, governance and risk management and reporting. Image 2 details the trend in assurance ratings of reviews over the period of 2018 – 2023, showing an increase in limited assurance reports over the last two years.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 18 April 2024 – 2023/24 overview



- Theme definition is included at Table 6.

Image 2: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 18 April 2024 – assurance ratings 2018 – 2023 (covering audit year 2023/24)



Executive Summaries

Special Measures – Contract and Procurement Review

BCU-2324-01

29 January 2024

Report opinion:

Assurance Not Applicable



Purpose: To assess the adequacy and compliance with the Health Board’s contract and procurement control framework.

Overview

The report found there are several areas of concern and non-compliance with the Standing Financial Instructions (SFIs) in relation to contracting and procurement.

- There are detailed operating procedures in place within NWSSP Procurement Services that outline the procurement process. However, the Health Board does not have any policy, procedure or guidance for staff on procurement and contract management, and the general finance procedures are out of date and require urgent review.
- Roles and responsibilities between the Health Board and NWSSP are clear, however there is scope to enhance the reporting and escalation process within the Health Board to ensure sufficient assurance is received from NWSSP, and the Health Board has early sight of issues relating to procurement.

- A detailed review of contracts highlighted some non-compliance with Health Board Standing Financial Instructions in relation to appropriate approval and signing of contracts.
- Contract management within the Health Board is inconsistent, with no instruction or guidance provided to staff who are responsible for managing contracts.
- There is no definitive list of contracts across the Health Board, with information received from services incomplete and inconsistent.
- The eWaiver system, which is used to request and approve single tender and quote waivers, does not ensure compliance with the SFIs, as it has no interdependency with the e-Financials system, and does not require the appropriate level of approval for waivers exceeding £25,000. The analysis of the eWaiver data shows that the Health Board is a significant outlier in terms of the number and value of waivers submitted, which raises questions about value for money and market competition.
- There has been no procurement training for Executives and all staff involved in procurement, to ensure full understanding of responsibilities and requirements, despite the previous recommendations from EY and internal audit.
- NWSSP Procurement Services maintain a forward work plan of areas requiring future contracts based on both current contracts in situ and Waive requests to ensure sufficient time is afforded to plan requirements, competition, quotes etc. We found no evidence of a similar practice for the contracts managed directly by Health Board staff and not recorded on the eCM register.

From our analysis of the information made available to us, we developed twenty four (24) Actions for consideration by the Health Board, NWSSP Procurement Services and Welsh Government. These are detailed in the report.

Follow up of audit recommendations

BCU-2324-22

29 February 2024

Report opinion:

Assurance Not Applicable



Purpose: To review the evidence received by the Office of the Board Secretary to support closure of a number of audit actions from various audit reports, as requested at the January 2024 Audit Committee.

Overview

- Of the 31 actions reviewed, there was sufficient evidence available to support the closure of 17 actions.
- We consider 6 actions to be partially closed, where some evidence has been provided but this does not demonstrate full completion of the agreed action.
- We consider 8 actions to be outstanding, where either no evidence was provided, or the evidence provided was not sufficient to support closure of the actions.
- Recommendations / agreed actions plans where the evidence is not sufficient and further evidence is required to close, are from the following reports:

- Integrated Service Board Governance
- Charitable Funds
- Recruitment of Substantive and Interim Executive and Senior Posts (ESP)
- Performance Management – Quality and Performance Reporting and Accountability Arrangements
- Clinical Audit – Tier 1 National Audits
- Falls Management
- MH&LD
- Audit Wales CHC Follow up
- Financial Control – Receipting of goods and year end accruals
- Accounts Receivable

Deprivation of Liberty
Safeguards

BCU-2324-27

16 April 2024

Report opinion:

Limited



Purpose: We reviewed the process in place for the management of Deprivation of Liberty Safeguards (DoLS) activity in the Health Board, including procedures, staff training, monitoring and escalation of cases.

Overview

There are adequate systems and processes in place for the management of DoLS applications, however issues of compliance exist and fall outside the direct control of the DoLS team.

The matters requiring management attention are:

- Compliance with Mandatory Mental Capacity Act training for Bank, Locum and Honorary staff are low and require addressing.
- A review of applications for December 2023 shows that a considerable number of applications (63.2%) were not assessed within the timescales required and took more than fifteen days to complete.
- Many applications for December 2023 (40.9%) were returned to the managing authority (wards / staff), due to poor quality i.e. not fully complete, impacting on the timescales of completion.
- A Mental Health Act Compliance and Capacity Committee had not convened since 10 February 2023. The Health Board Mental Health Legislation Compliance and Capacity Committee has now been established and convened on 11 January 2024.

Objectives

Assurance

| | | |
|---|--|-------------|
| 1 | The Health Board has appropriate processes and guidance in place. | Substantial |
| 2 | Appropriate training on DoLS is provided to all relevant staff. | Reasonable |
| 3 | Requests for urgent and / or standard DoLS authorisations are made within the required timescales. | Limited |

| | | |
|---|---|------------|
| 4 | DoLS documentation is completed fully, of appropriate quality and authorised by the Supervisory Body. | Limited |
| 5 | Systems and processes are in place for monitoring and reporting compliance with DoLS activity. | Reasonable |

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 | Mandatory MCA training levels 1 and 2 compliance figures for Bank, Locum and Honorary staff are low. | 2 | Operation | Medium |
| 2 | DoLS applications did not meet the timescale criteria and took more than 15 days to complete. | 3 | Design | High |
| 3 | Many applications are being returned due to either being incomplete or not of appropriate quality. | 4 | Operation | High |

Work in Progress Summary

4. The following draft reports have been issued:

Table 1: Draft Reports issued.

| Review | Status | Date draft report issued | Management response due |
|-----------------|--|--------------------------|---|
| Health & Safety | A management response has been received, however we were unable to agree to the actions for three recommendations. Management are reviewing these. (no change since last progress report and we have issued a follow-up reminder for management action) | 23 January 2024 | 20 February 2024 (received 19 February 2024) |

| Review | Status | Date draft report issued | Management response due |
|---|---|--------------------------|-------------------------|
| Operating Model | Awaiting management response. | 11 March 2024 | 19 April 2024 |
| Discharge Arrangements – Discharge to Recover then Assess (D2RA) Pathways | Comments on report have been received and are being reviewed. | 10 April 2024 | 9 May 2024 |
| Effective Governance – Womens | Awaiting management response. | 15 April 2024 | 13 May 2024 |
| Records Management – Fragmented Care records | Awaiting management response. | 16 April 2024 | 15 May 2024 |

5. The following 2023/24 reviews are currently in progress:

Table 2: Reviews in progress

| Review | Draft report due: |
|--|---|
| Budgetary control | April 2024 – fieldwork is complete, quality review is underway. |
| Effective Governance: Central IHC | April 2024 |
| Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005. | April 2024 – delayed due to receiving information from management |
| Standards of Business Conduct | April 2024 |
| Risk Management | April 2024 |
| Grievance management | May 2024 |
| Orthopaedic Surgical Hub Llandudno Hospital | April 2024 |

Contingency/Organisational Support/Advice

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

Delivering the Plan

8. The additional support provided to the Health Board with focused reviews is channelled through contingency
9. As new risks are identified in year, the Director of Corporate Governance and internal audit will consider the planned reviews against the emerging high-level risks.
10. It has been requested that the following audit be deferred from the 2024/25 plan agreed at the March 2024 Audit Committee:

Table 3: Audit review requested for deferral from the 2024/25 plan

| Audit Title | Reason for requesting deferral / removal from plan |
|--|---|
| Contracted patient services: Quality and safety arrangements (Follow up) | <p>We are advised that agreed management actions have not been progressed to enable a review in line with the approved plan.</p> <p>It is of concern there has been no progress following the 'no assurance' report issued in May 2023. This review was also deferred from the 2023/24 plan to enable management action to address the issues identified. We are unsighted on any alternative mitigating controls to address the significant risks identified in the previous review.</p> <p>The request for deferral is supported by the Director of Corporate Governance.</p> |

11. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5) with the assurance rating provided.
12. Table 4 is reporting a positive status across all indicators. Figures are based on twenty-one reports/briefing papers issued as final (or requiring no response) to date.

Table 4: Performance Indicators

| Indicator | Status | Actual | Target | Red | Amber | Green |
|--|--------|--------|--------|-------|-----------|-------|
| Report turnaround: time from fieldwork completion to draft reporting [10 days] | Green | 100% | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] | Green | 86% | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 days] | Green | 100% | 80% | v>20% | 10%<v<20% | v<10% |

Table 5: Core Plan 2023-24 (April 2023 to March 2024)

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|---|------------------------|------------------------|---|
| Special Measures - Contract and Procurement management review | October 2023 | Draft report issued. | Not Applicable |
| Financial Control: Receipting of goods and year-end accruals | April 2023 | Final report issued. | Reasonable |
| Accounts Receivable | June 2023 | Final report issued. | Reasonable |
| Clinical Audit: Tier 1 National Audits | June 2023 | Final report issued. | Limited |
| Falls management | June 2023 | Final report issued. | Limited |
| Lessons learnt | July 2023 | Final report issued. | Limited |
| Cyber security | April 2023 | Final report issued. | Substantial |
| Digital Operating Model | June 2023 | Final report issued. | Reasonable |
| GP Out of Hours (Deferred from 22/23) | June 2023 | Final report issued. | Limited |
| Decarbonisation | September 2023 | Final report issued. | Limited |
| Adult and Older Persons Mental Health Unit (IAAP) | April – September 2023 | Final report issued. | Reasonable |
| Corporate Legislative Compliance: Water Safety | June 2023 | Final report issued. | Limited |
| Hergest Unit Notice of Contravention (NoC) Action Plan | June 2023 | Final report issued. | Limited |
| Procurement and Contract management arrangements | June 2023 | Briefing paper issued. | Not Applicable |

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|---|---------------------------|------------------------|---|
| Interim Executive Director appointment | September 2023 | Briefing paper issued. | Not Applicable |
| Follow up - Delivery of HB Savings | October/ November 2023 | Final report issued. | Limited |
| Follow up - Welsh Language Commissioner - Documents on the Website | August 2023 | Final report issued. | Reasonable |
| Health and Safety | October 2023 | Draft report issued. | Limited |
| Digital Health Record (Cito) – Patient Records Transition Programme | November 2023 | Final report issued. | Substantial |
| Follow up of Internal Audit Recommendations | October 2023 – March 2024 | Final report issued. | Not Applicable |
| Deprivation of Liberty Safeguards (DoLS) | January 2024 | Final report issued. | Limited |
| Operating model | November 2023 | Draft report issued. | Unsatisfactory |
| Discharge arrangements / patient flow management | October 2023 | Draft report issued. | Limited |
| Records Management – Fragmented Care records | February 2024 | Draft report issued. | Reasonable |
| Effective governance - Women's Directorate | November 2023 | Draft report issued. | Reasonable |
| Budgetary Control | December 2023 | Fieldwork complete. | |
| Effective Governance - Integrated Health Community – Central | October 2023 | Review in progress. | |
| Standards of Business Conduct – Declarations of | December 2023 | Review in progress. | |

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|--|---------------------------|---------------------|---|
| Interest, Gifts and Hospitality | | | |
| Corporate Legislative Compliance: NHS Appointment of Consultant Regulations 2005 | November 2023 | Review in progress. | |
| Risk Management | February 2024 | Review in progress. | |
| Grievance management | February 2024 | Review in progress. | |
| Orthopaedic Surgical Hub Llandudno Hospital | February 2024 | Review in progress. | |
| Wrexham Maelor Continuity | October 2023 – March 2024 | Deferred. | |
| Workforce Strategy: Operational implementation (Deferred from 22/23) | June 2023 | Deferred. | |
| Follow up - Recruitment of substantive and interim executive and senior posts | December 2023 | Deferred. | |
| Charitable Funds | January 2024 | Deferred. | |
| Follow up – Contracted Patient Services: Quality and Safety arrangements | January 2024 | Deferred. | |

Audit Assurance Ratings

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

| | | |
|--|---------------------------------|--|
|  | 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. |
|  | Unsatisfactory | 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. |

Table 6: Themes and definitions relating to Image 1

| Ref. | Theme | Definition |
|------|-----------------------------|---|
| 1 | Cyber & Data Management | Management of IT systems and data is inadequate, access rights are not monitored or maintained which may compromise cybersecurity. |
| 2 | Communication | Information is not communicated clearly internally within teams, or externally with partners, forums, or wider stakeholders. |
| 3 | Compliance | Non-compliance with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation. |
| 4 | Policies & Procedures | Inadequate or lack of policies and procedures in place. |
| 5 | Audit Trail (Documentation) | There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail. |
| 6 | Engagement | Lack of engagement with staff, partners, and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored. |

| Ref. | Theme | Definition |
|------|--|--|
| 7 | Governance & Risk Management | Formal governance routes are inadequate, ineffective, or there is a lack understanding of them. This may affect the ability to identify, assess and manage risk. |
| 8 | Ineffective Controls | The necessary control(s) to mitigate risk(s) do/does not exist, is ineffective, or there are gaps which result in inefficiencies. |
| 9 | Reporting | The adequacy, quality, or accuracy of reporting is insufficient for assurance, or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions. |
| 10 | Finances & Resourcing | There are inadequate resources to deliver required tasks, a lack of resource management, monitoring, or funding. Financial viability and sustainability need to be properly considered and maintained. |
| 11 | Review | Whilst work is in progress and when it is completed, reviews are not undertaken regularly (or at all) to ensure quality, effectiveness and that the desired outcome is achieved or is on target to be achieved. Best practice is not reviewed or considered, lessons learned are not monitored or documented which may impact development and lead to repeated mistakes. |
| 12 | Physical Security | No consideration and actions to protect against current and future threats. |
| 13 | Planning, Delivery & Deadline Management | A lack of timescales or deadlines being set, or unmonitored scope creep resulting in missed deadlines, non-delivery of projects and/or tasks, overspends, or negative impacts on the quality of the final output. |
| 14 | Training & Development | A lack of training, opportunities to complete training, or training materials within teams; this may lead to gaps in knowledge and over reliance on certain staff members. |
| 15 | Contractual | Awaiting definition. |
| 16 | Strategy | Awaiting definition. |
| 17 | Other | If there is no correlation between a recommendation and one of themes outlined, this option can be selected to help monitor the accuracy of the list provided and to identify potential additional themes. |

Special Measures – Contract and Procurement Review

Final Internal Audit Report

January 2024

Betsi Cadwaladr University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
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University Health Board



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| | |
|-------------------------------|--|
| Review reference: | BCU-2324-01 |
| Report status: | Final Internal Audit Report |
| Fieldwork commencement: | 4 September 2023 |
| Fieldwork completion: | 30 October 2023 |
| Debrief discussion: | 19 October 2023 |
| Draft report issued: | 31 October 2023 |
| Management response received: | 27 January 2024 |
| Final report issued: | 29 January 2024 |
| Auditors: | Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit |
| Executive sign-off: | Russell Caldicott, Interim Executive Director of Finance |
| Distribution: | Jonathan Irvine, Director of Procurement, NWSSP Claire Salisbury, Assistant Director of Procurement Services, NWSSP Wyn Owens, Interim Head of Procurement (BCUHB), NWSSP Sian Owens, Deputy Head of Procurement (BCUHB), NWSSP Andrea Hughes, Interim Finance Director: Operational Finance |
| Committee: | Performance, Finance, and Information Governance & Audit Committees |



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

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

Disclaimer notice - please note:

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

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

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

Executive Summary

The report finds that there are several areas of concern and non-compliance with the Standing Financial Instructions (SFIs) in relation to contracting and procurement.

The Key findings are:

- There are detailed operating procedures in place within NWSSP Procurement Services that outline the procurement process. However, the Health Board does not have any policy, procedure or guidance for staff on procurement and contract management, and the general finance procedures are out of date and require urgent review.
- Roles and responsibilities between the Health Board and NWSSP are clear, however there is scope to enhance the reporting and escalation process within the Health Board to ensure sufficient assurance is received from NWSSP, and the Health Board has early sight of issues relating to procurement.
- A detailed review of contracts highlighted some non-compliance with Health Board Standing Financial Instructions in relation to appropriate approval and signing of contracts.
- Contract management within the Health Board is inconsistent, with no instruction or guidance provided to staff who are responsible for managing contracts.
- There is no definitive list of contracts across the Health Board, with information received from services incomplete and inconsistent.
- The eWaiver system, which is used to request and approve single tender and quote waivers, does not ensure compliance with the SFIs, as it has no interdependency with the e-Financials system, and does not require the appropriate level of approval for waivers exceeding £25,000. The analysis of the eWaiver data shows that the Health Board is a significant outlier in terms of the number and value of waivers submitted, which raises questions about value for money and market competition.
- There has been no procurement training for Executives and all staff involved in procurement, to ensure full understanding of responsibilities and requirements, despite the previous recommendations from EY and internal audit.
- NWSSP Procurement Services maintain a forward work plan of areas requiring future contracts based on both current contracts in situ and Waive requests to ensure sufficient time is afforded to plan requirements, competition, quotes etc. We found no evidence of a similar practice for the contracts managed directly by Health Board staff and not recorded on the eCM register.

From our analysis of the information made available to us, we have developed twenty-four (24) Actions for consideration by the Health Board, NWSSP Procurement Services and Welsh Government. These are detailed throughout the report and in Appendix A. NWSSP Procurement Services should be actively involved in supporting the Health Board progress the actions assigned to it in this review.

1. Introduction

- 1.1 On 27 February 2023 the Minister for Health and Social Care announced that the Health Board would be escalated into Special Measures, the highest level of intervention in the escalation framework. To deliver the improvement required, the Health Board established a special measures framework underpinned by eight domains for improvement:
- Governance, board effectiveness and audit.
 - Workforce and organisational development.
 - Financial governance and management.
 - Compassionate leadership and culture.
 - Clinical governance, patient experience and safety.
 - Operational delivery.
 - Planning and service transformation.
 - Clinical services.
- 1.2 Within the Financial Governance and Management Domain, a review of contract and procurement management was identified. A Terms of Reference for the review was developed by the Health Board and Welsh Government. NWSSP Audit & Assurance Services were requested to undertake the review in line with the Terms of Reference.
- 1.3 An assurance rating has not been applied to the review, we have made recommendations, where applicable, aimed at improving and/or enhancing expected controls in both procurement and contract management arrangements.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our 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: Overview of current arrangements:

- **Summarise all areas of contracting and procurement across the Health Board and draw out the areas of focus of this review and be clear on the rationale for areas not focussed on.**
- **Outline the contracting cycle and the current policies, procedures, and processes across the cycle, undertaken by health board operational staff and finance staff, and by the NWSSP local procurement team and NWSSP centrally.**

Contracting and Procurement across the Health Board

- 2.1 We contacted all corporate functions and clinical divisions and sent twenty email requests and received sixteen replies to the following:
- Details of all active contracts, including start/end dates, value and contract leads/managers.
 - Details of the Standard Operating Procedures concerning procurement and contract arrangements.

No response was received from Integrated Health Community – East; Integrated Health Community West; Office of the Board Secretary; and People & Organisational Development by the timeline set for replies.

Action: Health Board - The Health Board needs to understand why these four services did not respond by the timeline set.

- 2.2 Using the information provided we identified a sample to test which cut across all Health Board areas, bar those who did not respond to our request for information.
- 2.3 We noted at the outset that a small number of areas were able to rapidly provide the required information with the detail required and wish to highlight good practice and opportunity for learning across the Health Board from Pathology, Medical Physics (including Electro Bio-Medical Engineering), Operational Estates, and Healthcare Contracting.
- 2.4 We received varying levels of information with analysis of the information suggesting there is generally poor contract awareness and management arrangements operating across the Health Board. We concluded that the Health Board does not have robust contract information to hand and limited management arrangements to effectively oversee the delivery and value for money of the services procured.
- 2.5 We also sought contract details from NWSSP Procurement Services which they have actioned on behalf of the Health Board. We were provided with a copy of their 'eCM' spreadsheet which identified three hundred and eighteen (318) contracts they are actively involved with.
- 2.6 We sought to data match both sets of data with Accounts Payable data but due to inconsistencies in the naming of supplier details we were unable to compile a definitive list. We found instances where the 'eCM' data had three different ways of recording the supplier e.g. 'plc'; 'and'; '&'; for one supplier.

Action: NWSSP Procurement Services - The Supplier Header in 'eCM' data is consistent as set-up in Oracle e-Financial.

Policies and Procedures

- 2.7 The NHS Wales Model Standing Financial Instructions (SFIs), as adopted by the

Health Board are explicit in the roles and responsibilities concerning procurement and contract management and read in conjunction with Health Board Standing Orders (SOs) are the key governing documents that must be complied with.

- 2.8 Underpinning the SFIs and SOs, the first line of assurance/defence consists of all operational functions that own and manage the services and their associated risks. These are officers who are directly involved in delivering the organisation's objectives and ensuring compliance with policies and procedures.
- 2.9 We reviewed the Health Board's own procedures focusing on procurement and found no specific procedure to ensure officers comply with the requirements of the SFIs. Our review of the Finance Directorate procedures found that twenty-one were listed with all except four out of date and requiring review with some review dates noted as 2019.
- 2.10 As part of our review, we located a predecessor NHS Wales Trust organisation's SOs and SFIs to identify how they ensured the requirements of the SFIs were translated into operational procedures/guidance. We found that the former North West Wales NHS Trust SFIs recorded Policy/Procedure references against SFI headings e.g. Procurement, thus ensuring the SFIs were integrated into operational procedures.

| |
|---|
| Action: Health Board – The Executive Director of Finance ensures the current finance procedures are reviewed with urgency and a full review of the SFIs is undertaken to identify gaps in published procedures to guide/instruct the Health Board in complying with the SFIs. |
|---|

- 2.11 NWSSP Procurement Services (NWSSPPS) have a defined role within the SFIs to maintain policies and procedures on behalf of the Health Board, detailed as follows:
- 11.2.1 NWSSP Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts. included as **Schedule 1** of these SFIs.*
- 11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures.*
- *Are kept up to date;*
 - *Conform to statutory requirements and regulations;*
 - *Adhere to guidance issued by the Welsh Ministers;*
 - *Are consistent with the principles of sustainable development.*
- 2.12 The Document Management System (DMS) intranet site maintained by NWSSP provides details of current policies, procedures and documents and is comprehensive and appears to comply with the requirements of SFI 11.2.1. We are unable to confirm that all aspects of the SFIs are captured or where assurance

from NWSSPPS is formally reported to the Health Board.

- 2.13 Part of this review considered Health Board compliance with quotations; Procedure PS-QUO-01 – Quotations provides detailed guidance for NWSSPPS and signposts to the *'All Wales SQA/STA Request form'* which we reviewed. The review identified that the current form and process does not comply with the requirement of SFI 11.13.2 in relation to *"The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000."*

Action: NWSSP Procurement Services – The Director of Procurement Services:

- Ensures all policies, procedures and guidance documents are up to date in line with the Standing Financial Instructions.
- Provides an annual assurance report to the Chief Executive, who is ultimately responsible for procurement in the Health Board, of compliance with the Standing Financial Instructions, including a summary of any breaches with expected procurement controls.

- 2.14 NWSSPPS developed a *'All Wales Procure to Pay e-Manual for use by Health Organisation'* and this is very detailed and easy to follow and we recognise as good practice. We were advised the e-manual was circulated by the Finance Academy to all NHS Wales organisations. We were not aware of the manual and were also not signposted to it by anyone contacted through this review, suggesting the circulation was limited and not distributed widely in the Health Board.

Action: NWSSP Procurement Services and Health Board – The *'All Wales Procure to Pay e-Manual for use by Health Organisation'* content is reviewed and updated where necessary and NWSSPPS works with the Health Board to actively publicise it.

- 2.15 Through our review, we noted that predecessor NHS Wales Trust organisations' Model Standing Orders, issued by Welsh Government, recorded a competitive tender limit of £50,000 with quotations required over £5,000. The current Model Standing Financial Instructions has a tender limit of £25,000. We also noted that the Standing Orders excluded the ability for an organisation to support a Single Tender/Quote Waiver where *"...Failure to plan the work properly is not a justification for a single tender;"*

Action: Welsh Government –

- Review of the current tender limit is considered, whilst recognising the financial pressures facing NHS Wales.
- Consider enhancing the Standing Financial Instructions to exclude NHS Wales organisations from completing and approving Waivers based on timescales.

- 2.16 Whilst outside the scope of our review, we recognise the UK Government

introduced the Procurement Bill to the House of Commons in January 2023 with an expected 'go live' date of October 2024 noted. Whilst the review has focused on compliance with current process, we are not sighted on the arrangements in place to ensure NHS Wales is ready for any changes, should the Bill receive Royal Assent.

Action: NWSSP Procurement Services – The Director of Procurement Services ensures NHS Wales is ready for any changes in the Procurement Bill to current process and provides updates to all NHS Wales Boards on any impacts of change – This is timebound.

Objective 2: In the context of the overview, identification of potential areas of concern in conjunction with:

- **Review of the Ernst & Young (EY) report findings and recommendations.**
- **Review of recent internal audit reports and any other relevant reviews.**
- **Review of single tender waiver process, including review of numbers and specific instances of STW's reported over the last 12 months.**

EY report action plan

- 2.17 The *Forensic report of account issues*, sent by Ernst & Young (EY) in January 2023, identified a range of issues for the Health Board to address relating to governance, communication and training, and contract management. We have considered the actions relating to procurement and contracting, and actions taken by the Health Board to address these. This has involved a review of the Financial Control Environment Action Plan, which was developed by the Health Board's Finance team to address issues raised. We are advised that it incorporates findings from Audit Wales, EY and Internal Audit reviews, however a review of the plan highlights that there are no specific actions relating to a number of the EY recommendations, including a review of contract management procedures, contract extensions, managing contract costs and a review of key contracts.
- 2.18 We reviewed the action plan dated September 2023, noting that going forward actions will be incorporated in the Finance Special Measures Action Plan, as part of special measures work.
- 2.19 Whilst the Health Board is progressing actions, there remains further action in the following areas:
- Contract management – review of procedures, ensuring contracts are approved in line with policies and procedures, provide guidance on extension of contracts, controls relating to monitoring the limits of contracts, review of all key contracts to evidence compliance with requirements, and a formalised contract management system. We recognise that the Health Board is awaiting the

findings of this review to ensure focused action is taken to address this area of risk.

- Scheme of Reservation and Delegation (SoRD) – we recognise this has been reviewed and revised by Finance, with work ongoing to review delegated limits within operational areas, to ensure consistent practice across the Health Board.
- Review Audit Committee terms of reference and involvement in risk management, accounts processes and sign off of single tender waivers.
- Regular reviews of key policies and procedures – we are advised it is planned to review all Finance procedures.

We recognise that the Health Board is awaiting the outcome of this review, however the Health Board should confirm the actions it has taken / will be taking to address the recommendations raised.

Action: Health Board – To detail the actions taken / planned actions to address the specific recommendations detailed in the Ernst & Young report.

Internal Audit and other relevant reviews

2.20 An Internal audit review *Procurement: Contract Management and Single Tender Waivers* was undertaken in 2021. The key matters arising from this review were:

- Whilst there were monitoring and oversight of contracts, the formality of these arrangements varied across the Health Board.
- Whilst the eWaiver system had simplified the process for submission and approval of single tender waivers, it was not clear whether the conditions for approval are followed up (i.e. if all information relating to the request, such as previous STWs, was disclosed in the request).
- The NWSSP Contract database did not have up to date information for two contracts reviewed.

Actions agreed by the Health Board, and the latest status provided to us is detailed in the following table:

| Agreed action | Update |
|---|--|
| Produce a guide to service managers outlining key principles, minimum requirements for both contract specification and ongoing monitoring | Action closed. There is no narrative relating to this action, or evidence of action taken attached. |
| Review all relevant contracts to identify the level of risk of each contract with a view to reviewing, with procurement | Action closed. Progress update states: <i>Contract file attached and seperated into sections</i> |

| | |
|---|--|
| <p>colleagues, that appropriate arrangements are in place.</p> | <p><i>and risk assessed.(sic)</i> A list of risk assessed contracts provided, however it is not clear what further action has been undertaken following the initial assessment to confirm appropriate contract management arrangements are in place.</p> |
| <p>The Health Board will request a quarterly contract report from the NWSSP Procurement Services and review the detail at the relevant P2P meeting for accuracy. All inaccuracies will be flagged for update.</p> | <p>Action closed. Progress update states: <i>Quarterly review of the database will form part of the agenda and a formal review be undertaken at the finance P2P meeting.</i></p> |
| <p>To investigate the possibility of updating the eWaiver system to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended.</p> | <p>Action open: Progress update states: <i>Following a period of user testing the new system is now expected to go live at the end of August 2023. A communication plan for the launch is currently being developed to discourage use of STWs whilst promoting appropriate use of the new system. This is also subject to review fortnightly by WG as part of the Financial Control Environment Action Plan. Post implementation an assessment of impact will be conducted in September (revised date extended from March 2022 to end of September 2023)</i></p> |

2.21 We also reviewed audit actions directly relating to procurement and contract management (internal and external) – a total of 9 actions (including those detailed above).

- One remains open, as detailed in the table above.
- Five have been implemented – final client approved (Executive Director approved but not been followed up by audit).
- Two have been implemented – audit approved.
- One has been closed (not verified by audit based on the priority assigned to the recommendation).

Single Tender Waiver (STW)/Single Quote Waiver (SQW) process

2.22 NWSSPPS use the ‘All Wales SQA/STA Request form’ to govern and control all STW/SQW requests across NHS Wales bar the Health Board. The Health Board has since April 2019 used an in-house developed ‘eWaiver’ system.

2.23 The eWaiver system “...has been designed to streamline the process for completing a request to waive SFI’s...” and whilst we recognise the driver for doing so, we have found that the system does not interact with the e-Financials Purchase Order system.

It appears to be an electronic administrative system only which does not contribute to the expected controls underpinning the requisition/purchase order element of e-Financials and deliver on the requirement set out by the SFIs.

2.24 We are aware that the eWaiver system is subject to an update and requested details of the changes being applied on the 10 October 2023 but at the time of preparing this report we have not yet received a reply.

2.25 We obtained data for 2022/23 and 2023/24 from the Business Systems Team and identified the following high-level findings:

Table 1 – Waivers submitted by Year (includes all approved/rejected/awaiting action)

| Year | Count |
|-----------------------------|-------|
| 2019/20 | 30 |
| 2020/21 | 184 |
| 2021/22 | 338 |
| 2022/23 | 307 |
| 2023/24 (to September 2023) | 115 |

Source – Data extract provided by Business Systems 12 September 2023

Table 2 – Summary of the top fifteen waivers by count, submitted by Division (includes all approved/rejected/awaiting action)

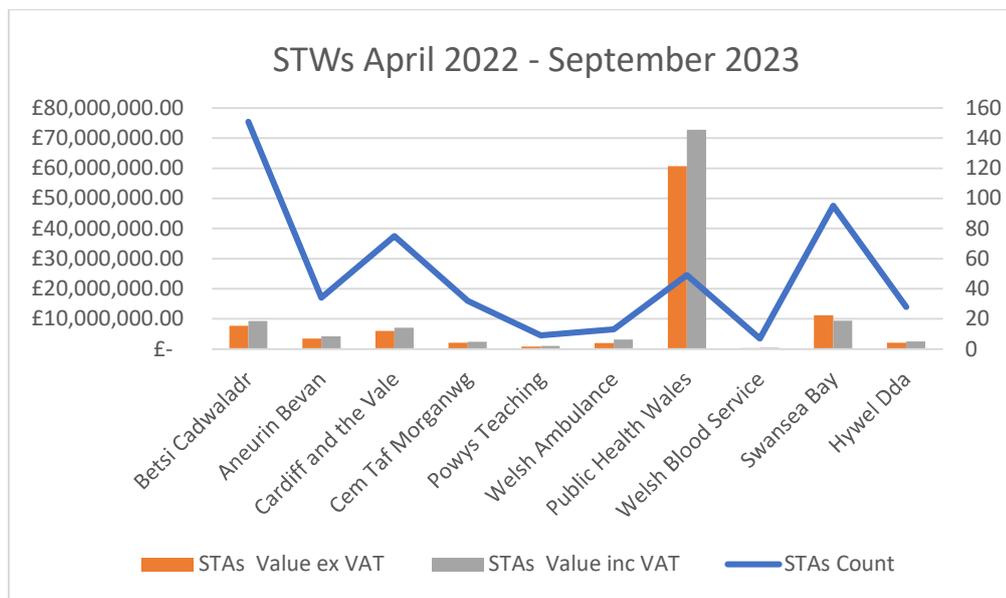
| Division | Type of Waiver | Count |
|------------------------|----------------|-------|
| Corporate | Tender | 117 |
| Mental Health & LD | Quote | 110 |
| Estates and Facilities | Quote | 83 |

| Division | Type of Waiver | Count |
|---|----------------|-------|
| Secondary Care - Managed Clinical Support | Quote | 78 |
| IHC Centre (Area Team - Central) | Tender | 63 |
| Corporate | Quote | 60 |
| Estates and Facilities | Tender | 50 |
| IHC Centre (Area Team - Central) | Quote | 44 |
| Mental Health & LD | Tender | 43 |
| Secondary Care - Managed Clinical Support | Tender | 39 |
| IHC East (Area Team - East) | Tender | 37 |
| IHC West (Area Team - West) | Tender | 37 |
| Capital | Quote | 29 |
| IHC West (Secondary Care - YG) | Quote | 29 |
| IHC Centre (Secondary Care - YGC) | Tender | 19 |

Source – Data extract provided by Business Systems 12 September 2023

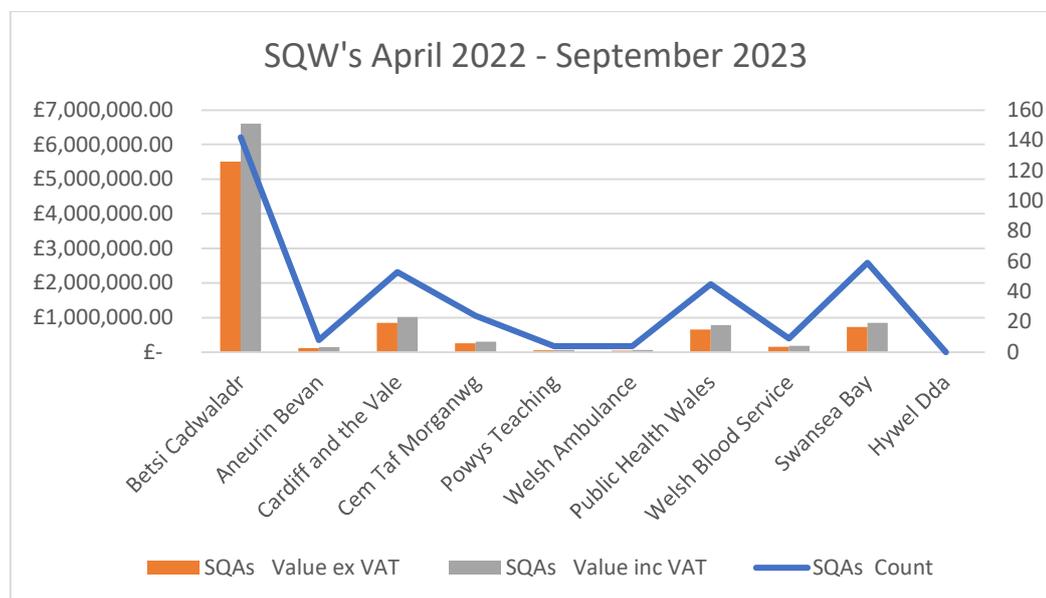
2.26 To ascertain how the Health Board compared with its peers in NHS Wales, we asked NWSSPPS to provide us with a summary of STW/SQW use in NHS Wales, with the following information received.

Graph 1 – NHS Wales summary of single tender waivers/actions (April 2022 to September 2023)



Source data provided by NWSSPPS 28 September 2023

Graph 2 - NHS Wales summary of single quote waivers/actions (April 2022 to September 2023)



Source data provided by NWSSPPS 28 September 2023

- 2.27 The review of data has identified that the Health Board is a significant outlier in the number of both tender and quote waivers submitted.
- 2.28 Consequently, through both volume and value, it is difficult for the Health Board to justify and evidence they have secured value for money in all cases, noting there will be exceptions where they have to go to one supplier for warranty/maintenance.
- 2.29 To complete the review of STW/SQW submitted through the eWaiver system, we reviewed the data and have identified the following high-level findings:

- Mandatory information required in the '*All Wales SQA/STA Request form*' is not evident in the system e.g. Whole life costs, Declaration of Interest does not require the eight statements to be answered, merely signposts to an online declaration form which we are unclear is verified as being completed.
- There is incomplete data in the recording of approval within the *Organisational Approval section - Finance Director Approval Decision*, where we found several noted as 'Accept' by the Finance Director to progress the waiver but no details of who the officer was, and date of approval both blank.
- The value of the figure recorded can be a mix of numeric and text which results in the actual value of waiver being unclear.
- Lead Executive Director approval of the service is not required in advance of the request being submitted to Procurement for consideration.
- The system is not complying with SFI 11.13.2 regarding "*The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000.*".
- Reasons for the waive requests are scant in some cases.
- We noted requests for Local Authorities and Third Sector and are unclear why other avenues are not being considered instead of STW/SQW.
- There is no control over who can submit a waiver, with access readily available. Previously NWSSPPS issued a checklist for requestors to complete which clarified whether a waiver could be submitted, this has subsequently been suspended but are unclear at whose request.
- We found evidence where NWSSPPS had rejected waivers but they had subsequently been accepted by the Finance Director. However, details of the officer and date were not recorded.
- We reviewed a sample of four waivers that had been submitted and were noted as "Waiver request - with Budget Holder" and followed them through the procurement process to see if they had been progressed. All except one had been progressed via a framework with one non-compliant and retrospective purchase orders raised to make payment and no tender/framework in place – value is £83,173.04 for professional services.

As these requests were 'sitting' in the eWaiver system and had not been approved, we reviewed whether purchase orders had been raised. All of these requests had purchase orders raised despite not being approved in the eWaiver system. All except one had been approved by officers with no documented delegated authority per the Health Board Scheme of Reservation and Delegation.

- The review of supporting narrative provided by NWSSPPS sometimes lacked the rigour to demonstrate scrutiny of the application in line with SFI 11.13.3 to include:

- *Robust justification is provided;*
- *A value for money test has been undertaken;*
- *No bias towards a particular supplier;*
- *Future competitive processes are not adversely affected;*
- *No distortion of the market is intended;*
- *An acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and*
- *An "or equivalent" test has been considered proving the request is justified.*

Action: Health Board – An urgent review of the eWaiver system is completed to ensure:

- It delivers the full requirements of the Standing Financial Instructions.
- It Interacts with the e-Financials System and is a key control to corroborate approval/rejection of waivers prior to any requisition and purchase order being approved and actioned.

Action: NWSSP Procurement Services – Ensure all STW/SQW applications are scrutinised to ensure compliance with Standing Financial Instruction 11.13.3 and reject where the criteria has not been met.

2.30 In line with SFI 11.13.5 *"As SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee."*

2.31 We reviewed the Financial Conformance reports prepared by Finance Directorate to the Audit Committee for 2022/2023 and 2023/2024 to the list of approved/rejected requests maintained in the eWaiver system and identified that all could be verified from the conformance report to the register.

However, it should be noted that there has been no finance conformance report for quarter 4 2022/23 at the time of this report.

Action: Health Board – The Chief Executive ensures the requirements of SFI 11.13.5 is complied with and the Audit Committee receive timely reports on waivers.

Objective 3: In Assessment - To assess the adequacy of both the design and compliance/implementation of controls across the contracting cycle, including in respect of the following aspects in particular:

- **Contract approval process controls, including WG approval where required, and compliance with those controls.**

- **Existence, and usage of contract registers as the basis for effective contract management and procurement planning.**
- **The application of the Scheme of Reservation and Delegation (SORD), including compliance with the requirement to procure expenditure and the appropriateness of use of the STW process, and compliance with the requirements of letting and approval of contracts.**
- **Whether the respective roles and responsibilities of NWSSP and Health Board staff are sufficiently clear, and whether there is adequate segregation of duties.**
- **Whether there are existing purchase orders with internal email or postal addresses, that would enable POs to be used internally only rather than externally where they are subject to third party aspects of control.**
- **Identifying any variation in practice and compliance levels across the Health Board and its various areas and divisions.**
- **Comparison with practice in other Health Boards.**
- **The adequacy of staff training, particularly staff outside finance and procurement functions.**

Contract approval process

2.32 NWSSP Procurement Services have a suite of procedures that are applied across NHS Wales to ensure all NHS Wales organisations comply with the mandatory approval process.

2.33 We reviewed a sample of contracts:

- Twelve (12) from the list of contracts provided by NWSSP Procurement Services.
- Forty-nine (49) from the information provided by Health Board staff / services.

2.34 Welsh Government and obtaining Welsh Government approval:

NWSSP Procurement sample: all that required Welsh Government approval/notifications (six) had the required returns and evidenced receipt of response. For one we noted the contract had been signed by the Health Board after the recorded start date.

Health Board sample: We identified eighteen that met the financial value criteria requiring Welsh Government approval/notifications of report and identified that:

- Seven had complied with Welsh Government reporting requirements.
- Ten were not applicable as they were either healthcare contracts or on a framework.
- One could not be corroborated as no document was provided.

2.35 Contract signed by a Health Board Executive (per standing orders)

Of the eight contracts provided by NWSSP Procurement Services (four of the twelve did not require a contract):

- Two were signed by an Executive Director (per SORD).
- Six had been signed by officers without delegated approval to sign contracts.
- We were unable to confirm that the contracts considered by the Board for approval had been Signed under Seal in accordance with SO 9.0.1.

Of the forty contracts provided by the Health Board (nine were not applicable due to national contract / contract let by Welsh Government etc.):

- Fifteen (37%) were signed by an Executive Director (per SORD).
- Five (13%) were not signed by an Executive of the Health Board.
- Nine (23%) Contracts were not provided.
- Four (10%) had no signature.
- Six (15%) where we were unable to verify (framework / WHSSC).
- One (2%) was awaiting signing.

Action: Health Board:

- The Board Secretary ensures Standing Order 9 – Signing and Sealing Documents is always complied with, in particular SO 9.0.1 where the Board has considered *"...a transaction to which the document relates has been approved by the Board."*
- The Chief Executive ensures contracts are signed in accordance with Standing Order 9.2.2 either by the Chief Executive or nominated officers delegated by the Board.
- The Scheme of Reservation and Delegation (SORD) is reviewed to ensure it complies with the requirements of Standing Order 9 as we noted the SORD delegates contract approval with limits to Executive Directors.

Contract registers

2.36 NWSSPPS maintain a list of contracts on their eCM register which records all contracts they are involved in. We contacted twenty corporate/operational functions in the Health Board to obtain details of the contracts they have in place. We did not receive a reply from four: People & OD, Office of the Board Secretary, IHC East and West (West sent their reply 2 October 2023, with the required reply of 13 September 2023).

2.37 We noted in responses that with the exception of Pathology, Operational Estates Services and EBME who were able to reply almost immediately, the remainder of the Health Board were reliant on other departments to provide the information. The Healthcare Contracts team maintain a register of healthcare contracts and

were a source of information to other functions.

2.38 There is no definitive list of contracts in place across the Health Board.

2.39 In terms of procurement planning, NWSSPPS hold a future work plan that incorporates all contracts they are involved in, with contracts flagged a period of time (i.e. 12 months) prior to the end date, to ensure sufficient time is allowed to review requirements and procure an appropriate supplier.

2.40 We are unable to confirm the forward planning in place for those contracts managed by the Health Board.

Action: Health Board -

- The Executive Director of Finance ensures Finance Policies/Procedures are developed that provide all Health Board staff responsible for procurement detailed guidance and expectations to ensure compliance with Standing Financial Instructions and expected control in contract management.
- Working with NWSSPPS, develops a composite contract register for the Health Board to ensure the risk of independent contract development is minimised and the Health Board maximises value for money where several contracts with a single supplier can be amalgamated.

Application of Scheme of Reservation and Delegation

2.41 The Health Board has a Scheme of Reservation and Delegation in place. The current approved version (August 2022) outlines delegated limits and is also clear on the requirements for signing contracts.

2.42 We reviewed the sample of contracts to determine if they were approved in line with the SoRD.

Of the twelve contracts provided by NWSSP Procurement Services:

- four were approved in accordance with the SoRD.
- three were not approved in accordance with the SoRD.
- five were unable to be verified.

Of the forty-nine contracts provided by the Health Board:

- thirty-one (63%) were approved in accordance with the SoRD.
- five (10%) were not approved in accordance with the SoRD.
- eleven (23%) were unable to be verified.
- two (4%) were national contracts.

2.43 The STW/SQW process is covered in objective 2 above.

Action: Health Board – To ensure the Scheme of Delegation is applied

appropriately in e-Financials, and is updated to ensure all of the organisation's structure is captured.

Roles and responsibilities

2.44 The Service Level Agreement (SLA) in place between NWSSP and NHS Wales is very high level, with the following identified as a link to delivery of procurement:

- NWSSP Role: Developing and delivering an agreed national and local savings and reporting strategy with on-going delivery. Including financial and non-financial social, economic and environmental sustainability benefits.
- Health Board Role: Providing requests for procurement that have been approved in line with relevant SFI and governance arrangements.

We can find no specific Key Performance Indicator (KPI) in place to report on matters of non-compliance with this measure.

2.45 Health Board Standing Financial Instructions (section 11 *Procurement and contracting for goods and services*) clearly outlines the roles and responsibilities of NWSSP Procurement Services and its responsibility in relation to policies and procedures. It also confirms the Chief Executive "...is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures."

2.46 We reviewed key job descriptions within the Finance, including the Integrated Health Community Chief Finance Officer, Chief Finance Officer for North Wales Services, Associate Director of Healthcare Contracts, Finance Director (operational).

2.47 All roles were clear in relation to procurement. The Finance Director Operational role includes "...to Act as the Health Board's strategic advisor on all Procurement matters ensuring compliance and the development of best practice with the Health Board Standing Financial Instructions; Procurement Law and other Guidance."

2.48 Whilst the NWSSP Head of Procurement reports to the Executive Director of Finance via the Finance Director (Operational), an alternative route of escalation, in the event of a conflict, should be in place via the Board Secretary.

2.49 In accordance with the Standing Financial Instructions and NWSSP Procurement procedures there is clear segregation of duties.

Action: Health Board and NWSSP Procurement Services – Review escalation routes within the Health Board for the Head of Procurement.

Purchase Orders

2.50 We reviewed all existing purchase orders to determine whether there were any internal email or postal addresses and noted the following:

- One hundred and sixty-five (165) suppliers where there were purchase orders with no fax or email recorded. We have not reviewed the reasons for this.
- The Health Board paid itself through Accounts Payable instead of journaling the expenditure: BCUHB Print Hub (email address of hotel facilities manager) £1,005.37.
- One supplier was set-up with a generic NWSSP Procurement email address - Halsall Crabtree Surgical Instrument Engineers - £2,520. We questioned this with the NWSSP Supplier Maintenance Team and were advised the supplier was set-up prior to the establishment of the Supplier Maintenance Team and therefore no records exist to corroborate why.

2.51 Whilst we were able to request and obtain these reports, they do not form part of the internal control process within the Health Board.

Action: Health Board and NWSSP Procurement Services – As part of the monthly meetings between both Finance & NWSSPPS, ensure reports pertaining to blank email/fax details in purchase orders are reviewed and corrective action taken to address irregularities.

Variation in practice and compliance levels

2.52 As noted in 2.37 above, the level of detail provided by services varied. We reviewed a sample of Health Board contracts and requested details on the contract management arrangements in place.

Of the twelve contracts provided by NWSSP Procurement Services:

- five had evidence of formal contract management arrangements, four of these include where NWSSP Procurement Services are involved in the contract.
- for the remaining seven we have not received evidence of contract management.

Of the forty-four contracts provided by the Health Board (five were not applicable / maintenance contracts):

- twenty five (57%) had evidence of formal contract management arrangements (i.e. meetings with suppliers, SLAs, KPIs).
- seventeen (39%) did not have evidence of contract management.
- two (4%) advised issues were raised as they arise (informal arrangements).

2.53 Whilst the majority of those reviewed had formal contract arrangements in place, there is no guidance provided or available to Health Board staff who are managing contracts.

2.54 From the information received, the following areas were able to provide us with the required contract information promptly, indicating they have a grasp on the contracts they are responsible for:

- Pathology
- Medical Physics (including Electro Bio-Medical Engineering)
- Operational Estates
- Healthcare Contracting

Action: See actions at paragraphs 2.14 and 2.40 in relation to contract management.

Comparison with other Health Boards

2.55 We met with the Director of Procurement Services, Deputy Director of Procurement Services and all Heads of Procurement to ascertain whether there were any differences in how Heads of Procurement manage relationships with their respective Health Boards.

All teams within NWSSP Procurement Services follow standard procedures for the procurement of goods and services. A quarterly performance report, which includes performance against KPIs is provided to the Health Board and presented by the Executive Director of Finance to the Performance, Finance and Information Governance Committee. Further assurance and reporting is determined by the requirements of each Health Board.

2.56 Within the Health Board, Finance provide procurement information and present this as part of the Financial Conformance report at Audit Committee. In some other Health Boards, NWSSP Procurement Services prepare the reports to Audit Committee on all elements concerning procurement and also attend to present the report – this is independent of Finance.

An example is Aneurin Bevan UHB Audit Committee papers for September 2023 that include a report on compliance, developed by Procurement Services and presented to the Committee. These papers are also in the public domain, whereas BCUHB publish their conformance report to the private meeting.

2.57 Through our meetings with NWSSP Heads of Procurement we were advised that services provided differ across organisations. We requested details of the services provided to each Health Board/Trust; at the time of writing this report we are still awaiting the information.

Action:

- Health Board – To review reporting arrangements with the local procurement team to determine requirements going forward, including Audit Committee reporting and attendance.

- NWSSP Procurement Services – To provide information to the Health Board on services provided to other Health Boards / Trusts.

Staff training

- 2.58 Internal Audit has previously identified the Health Board has not complied with the requirements stipulated by the Chief Executive of NHS Wales requiring that all Executive Directors and all officers involved in procurement must receive mandatory procurement training.
- 2.59 All new employees who require access to e-Financials procurement are required to complete on-line training before receiving a username. This went live in August 2023. We are not able to view the actual training, however a user guide was shared with us which indicates the type of training provided.
- 2.60 There is a training requirement plan in place that outlines Health Board Finance and Procurement training with key elements starting October 2023, but at the time of preparing this report we have not received any updated timelines.
- 2.61 In September 2023, the Interim Chief Executive confirmed to the Chief Executive of NHS Wales that they *"...expect the majority of colleagues to have received the SOs, SFIs and training/briefing within the next 3 months, and will individual follow-up for those who have not yet met the essential requirements."*

Whilst noting the ambition, we have not seen any timetable when and how the training is being delivered.

Action: Health Board – The Chief Executive receives an update from Officers responsible for facilitating and delivering procurement training which includes the timetable for delivery capturing all current posts, how new appointees will receive their training and what refresher training will be provided and how e.g. on-line training presentation.

Appendix A: Summary of Actions Identified

Health Board

1. Health Board - The Health Board needs to understand why these four services did not respond by the timeline set.
2. Health Board: The Executive Director of Finance ensures the current finance procedures are reviewed with urgency and a full review of the SFIs is undertaken to identify gaps in published procedures to guide/instruct the Health Board in complying with the SFIs.
3. NWSSP Procurement Services and Health Board: The 'All Wales Procure to Pay e-Manual for use by Health Organisation' content is reviewed and updated where necessary and NWSSPPS works with the Health Board to actively publicise it.
4. Health Board: To detail the actions taken / planned actions to address the specific recommendations detailed in the Ernst & Young report.
5. Health Board: An urgent review of the eWaiver system is completed to ensure it delivers the full requirements of the Standing Financial Instructions and interacts with the e-Financials System and is a key control to corroborate approval/rejection of waivers prior to any requisition and purchase order being approved and actioned.
6. Health Board: The Chief Executive ensures the requirements of SFI 11.13.5 is complied with and the Audit Committee receive timely reports on waivers.
7. Health Board: The Board Secretary ensures Standing Order 9 – Signing and Sealing Documents is always complied with, in particular SO 9.0.1 where the Board has considered "...a transaction to which the document relates has been approved by the Board."
8. Health Board: The Chief Executive ensures contracts are signed in accordance with Standing Order 9.2.2 either by the Chief Executive or nominated officers delegated by the Board.
9. Health Board: The Scheme of Reservation and Delegation (SORD) is reviewed to ensure it complies with the requirements of Standing Order 9 as we noted the SORD delegates contract approval with limits to Executive Directors.
10. Health Board: The Executive Director of Finance ensures Finance Policies/Procedures are developed that provide all Health Board staff responsible for procurement detailed guidance and expectations to ensure compliance with Standing Financial Instructions and expected control in contract management.
11. Health Board: Working with NWSSPPS, develops a composite contract register for the Health Board to ensure the risk of independent contract development

is minimised and the Health Board maximises value for money where several contracts with a single supplier can be amalgamated.

12. Health Board: To ensure the Scheme of Delegation is applied appropriately in e-Financials, and is updated to ensure all of the organisation's structure is captured.
13. Health Board and NWSSP Procurement Services: Review escalation routes within the Health Board for the Head of Procurement.
14. Health Board and NWSSP Procurement Services: As part of the monthly meetings between both Finance & NWSSPPS, ensure reports pertaining to blank email/fax details in purchase orders are reviewed and corrective action taken to address irregularities.
15. Health Board: To review reporting arrangements with the local procurement team to determine requirements going forward, including Audit Committee reporting and attendance.
16. Health Board: The Chief Executive receives an update from Officers responsible for facilitating and delivering procurement training which includes the timetable for delivery capturing all current posts, how new appointees will receive their training and what refresher training will be provided and how e.g. On-line training presentation.

NWSSP Procurement Services

17. NWSSP Procurement Services: The Supplier Header in 'eCM' data is consistent as set-up in Oracle e-Financial.
18. NWSSP Procurement Services: The Director of Procurement Services ensures all policies, procedures and guidance documents are up to date in line with the Standing Financial Instructions.
19. NWSSP Procurement Services: The Director of Procurement Services provides an annual assurance report to the Chief Executive, who is ultimately responsible for procurement in the Health Board, of compliance with the Standing Financial Instructions, including a summary of any breaches with expected procurement controls.
20. NWSSP Procurement Services: The Director of Procurement Services ensures NHS Wales is ready for any changes in the Procurement Bill to current process and provides updates to all NHS Wales Boards on any impacts of change – This is timebound.
21. NWSSP Procurement Services: Ensure all STW/SQW applications are scrutinised to ensure compliance with Standing Financial Instruction 11.13.3 and reject where the criteria has not been met.
22. NWSSP Procurement Services: To provide information to the Health Board on services provided to other Health Boards / Trusts.

Welsh Government

23. Welsh Government: Review of the current tender limit is considered, whilst recognising the financial pressures facing NHS Wales.
24. Welsh Government: Consider enhancing the Standing Financial Instructions to exclude NHS Wales organisations from completing and approving Waivers based on timescales.

Appendix B: List of Officers interviewed

Adrian Tomkins - Associate Director of Healthcare Contracting, BCUHB
Andrea Hughes - Interim Finance Director: Operational Finance, BCUHB
Carol Shillabeer – Interim Chief Executive & Accountable Officer, BCUHB
Claire Salisbury - Assistant Director of Procurement Services, NWSSP
Gillian Milne - Head of Healthcare Contracting, BCUHB
Jonathan Irvine - Director of Procurement, NWSSP
Michelle Phoenix – Audit Manager, Audit Wales
Richard Daniel - Interim Director of Capital & Estates, BCUHB
Sian Owens - Deputy Head of Procurement (BCUHB), NWSSP
Simon Monkhouse – Audit Lead, Audit Wales
Wyn Owens - Interim Head of Procurement (BCUHB), NWSSP

Appendix C: Acronyms

- BCUHB: Betsi Cadwaladr University Health Board
- DMS: Document Management System
- EBME: Electro Bio-Medical Engineering
- eCM: Electronic Contract Management
- e-Financials: Electronic Financials
- EY: Ernst & Young
- IHC: Integrated Health Community
- KPI: Key Performance Indicator
- LD: Learning Disabilities
- NWSSP: NHS Welsh Shared Services Partnership
- NWSSPPS: NHS Welsh Shared Services Partnership Procurement Services
- OD: Organisational Development
- P2P: Procure to Pay
- PO: Purchase Order
- PS: Procurement Services
- QUO: Quotations
- SFI: Standing Financial Instructions
- SLA: Service Level Agreement
- SO: Standing Orders
- SORD: Scheme of Reservation and Delegation
- SQW: Single Quote Waiver
- STW: Single Tender Waiver
- WG: Welsh Government
- WHSSC: Welsh Health Specialised Services Committee

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



GIG
CYMRU
NHS
WALES

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

Deprivation of Liberty Safeguards (DoLS)

Internal Audit Report

April 2024

Betsi Cadwaladr University Health Board



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



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Betsi Cadwaladr
University Health Board



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| | |
|-------------------------------|---|
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| Auditors: | Patrick Williams, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit |
| Executive sign-off: | Angela Wood, Executive Director of Nursing and Midwifery |
| Distribution: | Mandy Jones, Deputy Executive Director of Nursing Pam Wenger, Director of Corporate Governance Catrin Rhys Williams, Head of Corporate Office Hayley Lloyd, DoLS/MCA/LPS Regional Manager Chris Walker, Head of Safeguarding Adults |
| Committee: | Audit Committee |



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

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

Disclaimer notice - please note:

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Executive Summary

Purpose

We reviewed the process in place for the management of Deprivation of Liberty Safeguards (DoLS) activity in the Health Board, including procedures, staff training, monitoring and escalation of cases.

Overview

We have issued limited assurance on this area.

There are adequate systems and processes in place for the management of DoLS applications however issues of compliance exist and fall outside the direct control of the DoLS team.

The matters requiring management attention include:

- Compliance with Mandatory Mental Capacity Act training for Bank, Locum and Honorary staff are low and require addressing.
- A review of applications for December 2023 shows that a considerable number of applications (63.2%) were not assessed within the timescales required and took more than fifteen days to complete.
- Many applications for December 2023 (40.9%) were returned to the managing authority (wards / staff), due to poor quality i.e. not fully complete, impacting on the timescales of completion.
- A Mental Health Act Compliance and Capacity Committee has not convened since 10 February 2023. Health Board Mental Health legislation Compliance and Capacity Committee has now been established and convened on 11 January 2024.

We note there is currently a corporate risk relating to safeguarding, including DoLS (CRR 24-03). Actions are in place and being regularly reviewed. We have taken this into account in our recommendations.

Report Opinion

| | | Trend |
|--|--|---|
|  <p>Limited</p> | More significant matters require management attention. Moderate impact on residual risk exposure until resolved. |  Year of last issue 2019/20 |

Assurance summary¹

| Objectives | Assurance |
|--|-------------|
| 1 The Health Board has appropriate processes and guidance in place | Substantial |
| 2 Appropriate training on DoLS is provided to all relevant staff | Reasonable |
| 3 Requests for urgent and / or standard DoLS authorisations are made within the required timescales, | Limited |
| 4 DoLS documentation is completed fully, of appropriate quality, and authorised by the Supervisory Body. | Limited |
| 5 Systems and processes are in place for monitoring and reporting compliance with DoLS activity | Reasonable |

¹The 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 | Mandatory MCA training levels 1 and 2 compliance figures for Bank, Locum and Honorary staff are low. | 2 | Operation | Medium |
| 2 | DoLS applications did not meet the timescale criteria and took more than 15 days to complete. | 3 | Design | High |
| 3 | Many applications are being returned due to either being incomplete or not of appropriate quality. | 4 | Operation | High |

1. Introduction

- 1.1 The Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) Code of Practice provides legal protection for vulnerable people in NHS hospitals (including registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment. If a hospital (referred to as the managing authority) needs to deprive a person of their liberty, in their best interests, to keep them safe from harm, then the managing authority needs to apply for a DoLS authorisation through the DoLS team. Following assessments undertaken by a Best Interests Assessor and a Doctor, and providing the criteria is met, the Supervisory Body (Health Board DoLS Team) grants a Standard DoLS Authorisation allowing the hospital to lawfully deprive a person of their liberty.
- 1.2 Risks associated with the review are:
- Non-compliance with DoLS due to lack of process / awareness and delays;
 - Patients may be unlawfully deprived of their liberties;
 - The Health Board is unaware of issues relating to DoLS compliance;
 - Non-compliance with the MCA due to lack of awareness/training;
 - Inconsistent application of the MCA and DoLS; and
 - National Risks that have resulted in Welsh Government support and intervention, specifically in relation to the number of DoLS applications.

2. Detailed Audit Findings

In recent years, the number of DoLS applications has increased because of the reduced threshold for identifying a deprivation of liberty. The number of applications received by the Health Board is shown at Table 1 below.

Care Inspectorate Wales and Health Inspectorate Wales published a Deprivation of Liberty Safeguards report¹ that states:

A Supreme Court ruling in March 2014, known as the Cheshire West Judgement, clarified the definition and widened the scope of when someone is being deprived of their liberty...The 2014 Supreme Court ruling resulted in a very large increase in the number of applications for DoLS authorisations. The number of DoLS referrals has increased dramatically due to the reduced threshold for identifying a deprivation of liberty.

Table 1 DoLS applications per year

| Year | West | Central | East | England | Applications | % Change |
|---------|------|---------|------|---------|--------------|----------|
| 2018-19 | 89 | 257 | 343 | 55 | 744 | |
| 2019-20 | 177 | 282 | 483 | 72 | 1014 | ↑ 36.5% |
| 2020-21 | 208 | 322 | 550 | 82 | 1162 | ↑ 14.6% |
| 2021-22 | 251 | 333 | 925 | 120 | 1629 | ↑ 40.2% |
| 2022-23 | 267 | 352 | 824 | 134 | 1577 | ↓ 3.2% |

¹ Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2022-23

[Deprivation of Liberty Safeguards – Annual Monitoring Report for Health and Social Care 2022- 23 | Healthcare Inspectorate Wales \(hiw.org.uk\)](https://hiw.org.uk)

| | | | | | | |
|---------|-----|-----|-----|-----|-----------------------|---------|
| 2023-24 | 264 | 423 | 810 | 152 | 1649* (Forecast 1909) | ↑ 21.1% |
|---------|-----|-----|-----|-----|-----------------------|---------|

*Total received up to the end of January 2024

The UK Government passed the Mental Capacity (Amendment) Act 2019, extending to England and Wales. This was to replace DoLS with Liberty Protection Safeguards (LPS) which was intended to be a more streamlined version. In a statement by Welsh Government on 5 April 2023 it was announced that the UK government would be stepping away from the introduction of the LPS and the implementation of the Mental Capacity (Amendment) Act 2019. It was confirmed that the necessary legislation to implement the LPS will not be brought forward within this Parliament.

In 2022/23, the Welsh Government provided £8m of funding to support preparations for the LPS. A significant amount of that funding has been utilised to deliver Mental Capacity Act training and to manage the current DoLS system. Welsh Government has continued to provide funding at a comparable level to 2022/23 levels, to ensure that patient rights are protected ahead of any future implementation of the LPS.

Objective 1: The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS to avoid unlawful deprivations of liberty, this includes robust Procedures and Policies for the management of Court of Protection cases.

- 2.1 There is a DoLS Code of Practice (Deprivation of liberty safeguards), published by the Ministry of Justice, which details the DoLS process that must be followed. This code supplements the Mental Capacity Act 2005 Code of Practice. The statutory responsibilities of Managing Authorities [MA] and Supervisory Bodies [SB] is detailed within the Code, as well as key points for both the MA & SB (pages 104-106).
- 2.2 Information relating to DoLS is available to staff via the Safeguarding and Public Protection pages on BetsiNet. This includes Guidance, Standard Operating Procedures, time frames for standard and urgent applications, documentation to be used and relevant links to case studies. There is also a "Gold Standard Form 1 Example" that sets out what a fully completed and appropriate DoLS request should look like.
- 2.3 The key documents we reviewed are:
 - SA07 Standard Operating Procedure (SOP) – Deprivation of Liberty Safeguards – Review Date April 2026

The SOP provides the managing authority (ward managers and staff) within the Health Board a clear governance framework in relation to what a deprivation of liberty is and how to ensure any deprivation is lawful.

It covers the procedure (section 7) for identifying the conditions that must be met for the DoLS authorisation to apply, as well as the documents that must be completed for DoLS applications. Section 7.1 also provides a detailed description of the Supervisory Body responsibilities following the application of a DoLS by the managing authority.

- SCH19 - Standard Operating Procedure (SOP) Section 21A of the Mental Capacity Act – Review date April 2026

This document outlines the organisational and professional roles, responsibilities, and accountability when an application has been made to challenge a DoLS Authorisation, known as a Section 21A of the Mental Capacity Act 2005.

If the patient, who is subject to a DoLS authorisation, is objecting to their care arrangements, the managing authority, the patient's representative and/or any interested parties have an obligation to support the patient to exercise their rights of review under Section 21A of the Mental Capacity Act by making an application to the Court of Protection.

- SCH13 - Procedure for Supervision within the Corporate Safeguarding Team

This procedure recognises the importance of the supervision of employees in contributing to the safe delivery of the safeguarding agenda.

Conclusion:

- 2.4 There are up-to-date procedures and guidance in place to assist the DoLS application process, which are aligned with the DoLS Code of Practice (Deprivation of Liberty protections). Roles and responsibilities for Section 21A of the Mental Capacity Act 2005 (application for court of protection) are clearly defined within SCH19 SOP.

The BetsiNet website includes the necessary papers to complete the DoLS application, as well as valuable links and resources to assist staff.

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

Objective 2: Appropriate training on DoLS is provided to all relevant staff. We will consider MCA training and compliance due to the inherent link between DoLS and the Mental Capacity Act (MCA).

- 2.5 All staff in the Health Board receive appropriate to their role. There are three levels of training available.

- Level 1 – Basic Awareness of Mental Capacity Act. This is mandatory for all staff (unless progressing to level 2);
- Level 2 - Background to the Act and introduction to DoLS. This is mandatory for all clinical staff and their managers (unless progressing to Level 3); and
- Level 3 – Covers DoLS in more depth, including assessing capacity, and local processes. This includes scenarios and is discussion based. This is for all clinical staff at Band 5 and above, and their managers.

Both levels 1,2 are mandatory training delivered through E- Learning via ESR (Electronic Staff Record), with a workbook format available for those who do not have access to ESR. Level 3 is delivered through Microsoft Teams and is not currently mandatory. Table 2 below shows compliance figures provided by the Corporate Safeguarding team.

Table 2. MCA level 1 and 2 training compliance as 31 January 2024

| Contract Type | Mental Capacity Act Level 1 | | | Mental Capacity Act Level 2 | | |
|--------------------------|-----------------------------|---------------|--------------|-----------------------------|---------------|--------------|
| | Compliant | Non-Compliant | Compliance % | Compliant | Non-Compliant | Compliance % |
| Permanent and Fixed Term | 18,381 | 2,879 | 84.3% | 12,747 | 1,930 | 84.8% |
| Bank, Locum and Honorary | 8,283 | 4,010 | 51.5% | 6,795 | 3,425 | 49.5% |
| Total | 26,664 | 6,889 | 74.2% | 19,542 | 5,355 | 72.5% |

Since March 2021, a total of 35 Level 3 sessions have been delivered reaching 747 staff.

Table 3: Mental Capacity Level 3 attendance

| Year | Sessions | Staff Attended |
|--------------|-----------|----------------|
| 2021 | 10 | 301 |
| 2022 | 11 | 144 |
| 2023 | 12 | 271 |
| 2024 | 2 | 31 |
| Total | 35 | 747 |

- 2.6 There are currently six Best Interest Assessors (BIA) within the Supervisory Body. All of these hold the Best Interest Assessor qualification, to master's level. This is a qualification that is listed as essential on the Job Description/Person Specification.
- 2.7 In addition to Levels 1, 2, and 3, the Corporate Safeguarding team have created a 30-minute MCA/DoLS overview training session. Where non-compliance or issues around paperwork completion are found, this training is provided directly to staff and wards to increase understanding and raise awareness of the Mental Capacity Act (MCA).
- 2.8 The Corporate Safeguarding team with the additional money from the Welsh Government (WG) funding, has allowed them to provide a secondment opportunity. An MCA Trainer role has been created with the purpose of supporting the Health Board in achieving compliance with the MCA.
- 2.9 Utilisation of the WG funding the Supervisory Body (Health Board DoLS Team) has produced MCA educational materials such as banner pens with MCA principles, coffee mugs with MCA guidance, MCA booklets for employees, MCA easy read guides for patients and carers, posters, and other useful resources to promote MCA awareness, which are available to all staff.

Conclusion:

- 2.10 Welsh Government funding has supported extra Mental Capacity Act (MCA) training on the completion of Deprivation for Liberty (DoLS) applications.

The MCA level 3 training is currently in the process of being implemented as mandatory training.

All BIA assessors are all trained to the appropriate qualification.

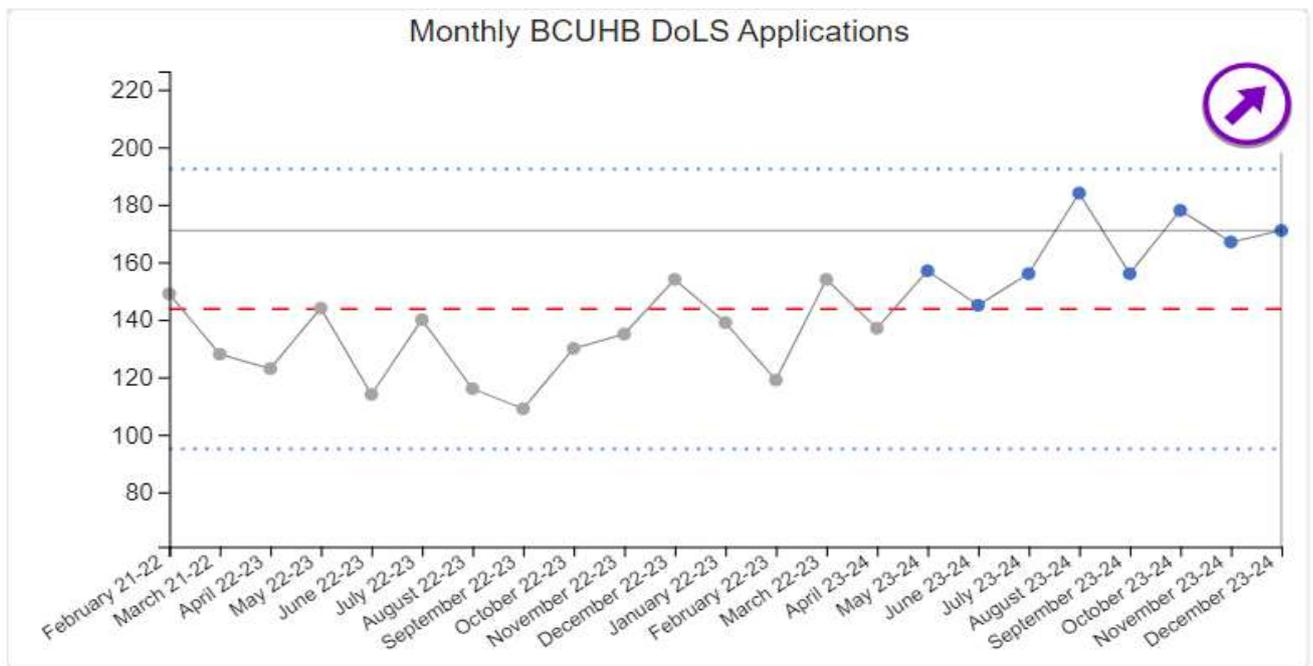
Bank, Locum and Honorary compliance training figures for MCA levels 1 and 2 are low and require and require improvement.

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

Objective 3: Requests for urgent and / or standard DoLS authorisations are made within the required timescales, and all requests are appropriately assessed (by a Best Interests Assessor and a Doctor, if appropriate) within statutory / reasonable timescales.

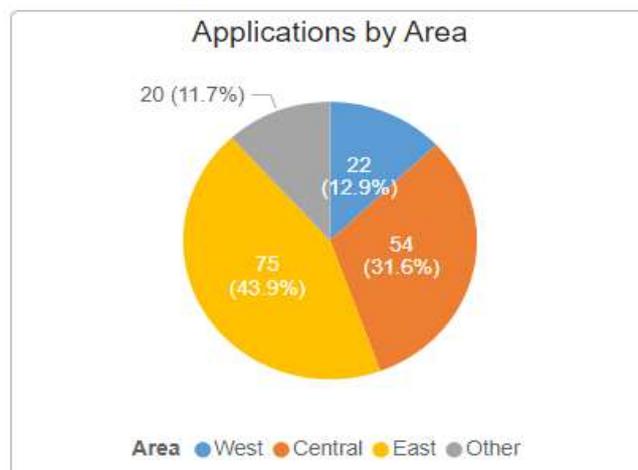
2.11 Figure 1 below illustrates the DoLS applications received between February 2022 and December 2023.

Fig.1: DoLS Applications



2.12 We sampled DoLS applications for December 2023. There were 171 DoLS applications received from across the Health Board during the month. Figure 2 below breaks down the applications received during December 2023 by area. A review of data shows the East area consistently submit the highest proportion of DoLS applications each month.

Fig.2: DoLS Applications by Area December 2023



2.13 An urgent authorisation can be granted for a period of up to seven days. The managing authority (health Board) can request to extend the authorisation for up to a further seven days. When granting an urgent authorisation, the managing authority must also make a request for a standard authorisation.

Below breaks down the applications received during December by type as well as the timescales for the applications received during December 2023.

Table 4: DoLS application by Type December 2023

| Type of Request | West | Central | East | Other | Total | % |
|---------------------------|-----------|-----------|-----------|-----------|------------|-------|
| Standard Following Urgent | 18 | 49 | 70 | 18 | 155 | 90.6% |
| Further / Re-assessment | 4 | 5 | 5 | 1 | 15 | 8.8% |
| Urgent | 0 | 0 | 0 | 1 | 1 | 0.6% |
| Total | 22 | 54 | 75 | 20 | 171 | |

Table 5: DoLS Applications Timescales

| Timescales | Applications Completed | % |
|---------------|------------------------|-------|
| Within 7 days | 39 | 22.8% |
| 8-14 days | 24 | 14% |
| 15 days + | 99 | 57.9% |
| Total | *162 | |

* 9 currently pending (5.3%)

- 22.8% (39) of the applications that were received during December 2023 were completed within the first seven days as they were withdrawn.
- 14% (25) applications were closed within the extension period. Two (2) were granted and the remaining twenty-three (22) were withdrawn.
- 57.9% (99) applications were completed outside the urgent applications (within 7 days) and extended applications (8 - 14 days) timescales.

Following discussion with the Health Board DoLS team (Supervisory Body), the ward managers / staff (managing authority) will not always inform them, within

the required timescale, that the patient no longer requires a DoLS, which will impact upon timescales and compliance.

2.14 Table 6 below breaks down the applications received during December 2023 by their outcomes.

Table 6: DoLS Applications outcomes December 2023

| Outcome | Total | % |
|--------------|------------|------|
| Withdrawn | 127 | 74.3 |
| Granted | 33 | 19.3 |
| Refused | 2 | 1.2% |
| Pending | 9 | 5.2% |
| Total | 171 | |

- Nine (9) applications that were received during December 2023 remain open at this time:
 - Six (6) applications have been assessed by both a BIA and a Doctor pending authorisation.
 - Two (2) have had the assessment completed by a doctor and have been allocated to a BIA, awaiting assessment.
 - One (1) application has been allocated a BIA awaiting an assessment and awaiting allocation and assessment with a doctor.

2.15 The Standard Operating Procedure (SOP) – Deprivation of Liberty Safeguards (DoLS) states:

7.1 Supervisory Body Responsibilities:

To assess that a person is deprived of their liberty, the Supervisory Body appoint two assessors, A Best Interest Assessor (BIA) and a Mental Health Assessor (a s12(2) Approved Doctor) to undertake the 6 assessments required under DoLS legislation.

Out of the 33 applications granted all had been allocated a BIA and a Mental Health Assessor (a s12(2) Approved Doctor).

2.16 The DoLS 'backlog' is a legal term recognised by Welsh Government (WG) referring to the number of applications awaiting authorisation. As of 22 February 2024, a total of 166 applications are currently outstanding. As well as MCA awareness the additional WG funding has also used to address the backlog.

2.17 Table 7, below, details the status of applications in the backlog. This is an improvement when compared to the beginning of February, when 174 applications were outstanding.

Table 7: Backlog breakdown 22 February 2024

| | |
|-------------------------------------|----|
| Urgent Applications (1-7 Days) | 15 |
| Extended Applications (8 - 14 days) | 44 |
| Applications Allocated to BIA | 19 |

| | |
|---|-----|
| Applications Allocated to Section 12(2) Doctors | 13 |
| Applications Pending Authorisation | 11 |
| Backlog (out of timescale with no allocations or pending authorisation) | 64 |
| Total | 166 |

2.18 We note the backlog issue has been recognised as a national issue. We were provided with funding letters received from Welsh Government, that sets out a clear direction around the spending criteria, one of which is the reduction the DoLS backlog and includes all Health Boards and Local Authorities.

Conclusion:

2.19 Although applications are being completed, our review of December 2023 applications shows that the majority of these (63.2%) were not completed within the required timescales.

We note that the Supervisory Body only has six qualified Best Interests Assessors to complete an increasing amount of DoLS applications within the Health Board. We were informed by the Supervisory Body that currently the Best Interest Assessors and Section 12 Doctors are completing assessments during evenings and weekends to reduce the backlog and ensure Health Board patients are protected by the Legal Framework.

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

Objective 4: DoLS documentation is completed fully, of appropriate quality, and authorised by the Supervisory Body. We will consider Independent Mental Capacity Advocate (IMCA) provision.

2.20 We reviewed the data for December 2023 to establish whether documentation was completed fully and appropriately. With the support of the Specialist Information Analyst, we were able identify the following:

- 40.9% (70) of the applications submitted during December 2023 were noted to have issues with the application form, the table below illustrates the applications with issues, by area.

Table 8: DoLS Applications with issues by area

| Area | Applications | Issues | % |
|---------|--------------|--------|-------|
| West | 22 | 13 | 59.1% |
| Central | 54 | 19 | 35.2% |
| East | 75 | 33 | 44.0% |
| Other | 20 | 5 | 25.0% |
| Total | 171 | 70 | 40.9% |

With the funding from Welsh Government being used to increase training/education, it is hoped the Health Board will see a decrease in issues with the applications.

- 2.21 The Supervisory Body record the issues for each application in eleven categories. The categories are highlighted in the table below along with the number of issues recorded against each for the applications received during December 2023.

Table 9: DoLS Application Issues December 2023

| Issue | Applications |
|---|--------------|
| A – Incomplete patient details (cannot accept) | 1 |
| B – Missing details regarding communication and medical information | 27 |
| C – Incomplete MA details | 0 |
| D – Section details missing (MHA only) | 0 |
| E – Urgent Authorisation not completed | 6 |
| F – Urgent Authorisation also completed (MHA only) | 0 |
| G – No Care and Treatment Plan (CTP) (MHA only) | 0 |
| H – No Consultant name (MHA only) | 0 |
| I – No Capacity Form | 14 |
| J – Capacity Form – issue: poor or wrong decision | 12 |
| K – Q10 or Q12 not completed correctly | 39 |

***Please note that some applications recorded multiple issues.**

Due to funding provided by the Welsh Government, the Supervisory Body has been able to provide a secondment opportunity to strengthen the system. The post holder is currently collaborating with the Managing Authorities (Wards) to ensure that any concerns with application forms are resolved as soon as possible to avoid delays.

- 2.22 Independent Mental Capacity Advocates (IMCAs) are a legal safeguard for people who lack the capacity to make specific important decisions should there be no nominated family member or friend available to carry out that task.

From sample testing it was established that there were five requests for a 39A IMCA, with all five patients having a 39A IMCA appointed.

The WG funding is also being provided to Health Boards to secure additional Independent Mental Capacity Advocates (IMCAs) resourcing. As with 2022/23, this funding is being provided to Health Boards to commission IMCA services across their geographical footprint.

Conclusion:

- 2.23 All applications are inspected by the Supervisory Body through the stages of the process, and where there are issues within the initial application the Supervisory Body will return to the managing authority.

A high number of applications (40.9% of overall applications for December 2023) have been returned due to not being of appropriate quality or missing information, impacting on the timescales of completion. The Supervisory Body can identify issues within the areas of the Health Board as well as categorise the issues. This

will support the Supervisory Body in targeting areas of concern with regards to training/education.

No issues were identified with the allocation of an Independent Mental Capacity Advocate for patients where this was requested.

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

Objective 5: Systems and processes are in place for monitoring and reporting compliance with DoLS activity, and any issues are appropriately escalated and actioned.

DoLS activity is monitored and reported through a governance structure detailed below.

2.24 Corporate Safeguarding Senior Leads Meeting – Monthly meetings

We were provided with minutes for 31 October and 21 November 2023 meetings, the following can be seen being discussed with the agendas.

- Cycle of business
- Policy and procedure trackers
- Risk Register - discussions on risks and determining how the risks are going to be met.
- Action Log for both Senior Leads Meeting and Safeguarding Governance and Performance Group Action Log. We note that within the action log for the Senior Leads Meeting there are 20 actions for safeguarding.
 - 1 Green - Complete
 - 13 Amber - Partially complete
 - 7 Red – Incomplete

2.25 Corporate Safeguarding Governance and Performance Group – Quarterly meetings

We were provided with minutes for the meetings on 18 July 2023 and 17 October 2023, we note the following being discussed within the minutes of the meetings.

- 18 July 2023 – Welsh Government (WG) non-recurring funding has been issued to the Health Board to support a reduction of the DoLS backlog and MCA activity This is a national issue which has been recognised by Welsh Government.
- 18 July 2023 – Risk register CRR21-14 DoLS risk, there was a request to reduce the risk from 20 to 16 due to the WG non-recurring funding. We can confirm that this was agreed at the Risk Management Group on the 8 August 2023.
- 17 October 2023 – Identifies there has been a reduction in the backlog due to the WG non-recurring funding, this can be seen within the Patient Safety Effectiveness Report due to be presented at the Quality, Safety and Experience Committee on 20 February 2024.
- 17 October 2023 – evidence discussions on Independent Mental Capacity Advocates (IMCAs).

- limited services within North Wales of the IMCA services, and
- BCUHB lead on the provision of IMCA services across our geographical area, funding has been provided by Welsh Government and links made with Local Authority's and IMCA services continue during 2023 – 2024.

2.26 Quality, Safety and Experience Committee (QSE) – bi-monthly meetings

DoLS compliance is monitored within the safeguarding reporting and not as a stand-alone report. A review of the QSE papers for 2023 shows the following reported re DoLS:

- 20 June 2023 – A Corporate Safeguarding Report was presented which includes DoLS compliance.
- 22 August 2023 – A Corporate Safeguarding Annual Report was presented which includes DoLS.
- 27 November 2023 – the proposed Cycle of Business (COB) for the Committee includes the provision of a Safeguarding annual report as well as quarterly Patient Safety Effectiveness Report (which include DoLS monitoring)
- 19 December 2023 – A Patient Safety Effectiveness Report was presented. We note the following within the report *“As of the end of Q3, the DoLS Backlog stands at 19 (the number of patients awaiting a DoLS Assessment). Prior to WG funding, the Health Board had a Backlog of 144 cases”*.
- 20 February 2024 – the agenda includes a Patient Safety Effectiveness Report, and a new COB (April 2024 – March 2025). This includes the delivery of an Integrated Quality Report containing information on Safeguarding and DoLS issues at each scheduled meeting, as well as an annual Safeguarding report for June 2024. The following was noted in the Patient Safety Effectiveness report:

“As of the end of Q3, the DoLS Backlog stands at 19 (the number of patients awaiting a DoLS Assessment). Prior to WG funding, the Health Board had a Backlog of 144 cases. The reduction is a testament to the work undertaken by the MCA/DoLS Team. Best Interest Assessors and Section 12(2) Doctors complete additional DoLS Assessments during evenings and weekends to ensure Health Board patients are protected by the Legal Framework”.

2.27 BCU Mental Health Legislation Compliance and Capacity Committee previously the Mental Health and Capacity Compliance Committee – quarterly meetings

A Mental Health Act Compliance and Capacity Committee was in place; however this has not convened since 10 February 2023, due to the number of Independent Members available.

An appropriate number of Independent Members have since been appointed to the Health Board and a committee meeting for the establishment of the Mental Health legislation Compliance and Capacity Committee took place on 13 December 2023.

We note a Mental Capacity Act (including DoLS) Assurance Report was presented to the meeting.

A Health Board Mental Health legislation Compliance and Capacity Committee took place on 11 January 2024, in which the committee was asked to review and endorse the Terms of Reference (ToR) as well consider the Cycle of Business (CoB) for 2024. The CoB for 2024 includes quarterly reports are to be presented throughout the year.

We note that the ToR state the frequency of meetings is bi-monthly however the CoB (April 2024 – March 2025) reports on a quarterly basis.

Conclusion:

2.28 Corporate Safeguarding reports, annual reporting and Patient Safety Effectiveness, reports all provide evidence of monitoring and reporting of DoLS activity and issues. Cycles of business can be seen throughout the structure identifying the reports which will be regularly presented for consideration.

2.29 The Mental Health Legislation Compliance and Capacity Committee has been established following the appointment of Independent Board Members, and replaces the Mental Health and Capacity Compliance Committee.

Whilst the Corporate Safeguarding Senior Leads Meeting and Corporate Safeguarding Governance and Performance Group report and escalate on DoLS work, the agendas and minutes do not contain any formal items for escalation.

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

Appendix A: Management Action Plan

| Matter Arising 1: MCA training levels 1 and 2 (Operation) | | Impact | |
|--|--|--|--|
| Mandatory Mental Capacity Act training compliance figures for Bank, Locum and Honorary staff are low: <ul style="list-style-type: none"> - Level 1 – 51.5% - Level 2 - 49.5% | | Potential risk of: <ul style="list-style-type: none"> • Staff not aware of their responsibilities under the MCA legislation | |
| Recommendations | | Priority | |
| 1.1a | Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate. | Medium | |
| Agreed Management Action | | Target Date | Responsible Officer |
| 1.1a | Undertake a review of MCA mandatory training data for Bank, Locum and Honorary staff and identify low compliance areas in each staffing group. | 30/09/2024 | Head of Safeguarding Adults, MCA and DoLS (Responsible for all actions) |
| | Identify staffing groups who have low compliance and provide data monthly to service leads to action. | 30/09/2024 | |
| | Review current BCUHB training policies and procedures with service leads for Bank, Locum and Honorary staff to ascertain current agreements in place in relation to the completion of MCA training prior to and during employment. | 30/09/2024 | |
| | Report monthly compliance of MCA training for bank, locum and honorary staff to IHC Safeguarding Forums for oversight and assurance. | 30/06/2024 | |

| | | | |
|--|--|-------------------|--|
| | <p>Re-launch awareness of the MCA and provide staff and services with materials to promote MCA training and compliance.</p> | <p>30/09/2024</p> | |
| | <p>Quarterly reporting into the Mental Health Legislation and Compliance Committee for monitoring, oversight and assurance, providing details of progress and highlighting areas of concern with additional actions and escalation agreed where necessary.</p> | <p>30/09/2024</p> | |

| Matter Arising 2: DoLS authorisations (Design) | | Impact | |
|--|---|--|--|
| <p>Urgent DoLS applications should be completed within 7 days, per the Mental Capacity Act Deprivation of Liberty Safeguards Code of Practice; urgent applications can be extended for an additional 7 days if necessary.</p> <p>Our sample (December 2023) revealed that 63.2% of applications did not match the timescale criteria and took more than 15 days.</p> | | <p>Potential risk of:</p> <ul style="list-style-type: none"> Patients are unlawfully deprived of their liberties. | |
| Recommendations | | Priority | |
| 2.1a | Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor). | High | |
| Agreed Management Action | | Target Date | Responsible Officer |
| 2.1a | Demand and capacity modelling for Best Interest Assessments to be developed by the Safeguarding Business Team to support data driven decisions. | 31/07/2024 | Head of Safeguarding Adults, MCA and DoLS (Responsible for all actions) |
| | Increase the Supervisory Body's capacity to complete best interest assessments within agreed timescales and legislative compliance by training 5 additional BIA's from Q2 onwards. | 31/03/2025 | |
| | Work Based Quality Improvement programme to be developed and implemented within the 3 high referring areas with high QA rejection rates for applications. | 30/09/2024 | |
| | Standard Operating Procedure for MCA and BIA service to be reviewed to strengthen visibility of the team within high risk areas. To include structured weekly visits/daily calls by the MCA Team to high referral areas i.e. DGH and Community Hospitals to increase profile of the MCA Team, provide support for staff, feedback regarding application QA rejection themes (date, signatures) etc. | 30/09/2024 | |

| | | |
|---|------------|--|
| Review/Promote training materials available at ward/department level to promote and provide examples of what good looks like. | 31/12/2024 | |
| Digitalise MCA and DoLS documentation to ensure that mandatory fields are completed prior to submission and audit standards. | 31/03/2025 | |

| Matter Arising 3: DoLS Documentation (Operational) | | Impact |
|--|---|--|
| <p>From our sample (December 2023) 40.9% of overall applications have been returned due to either being incomplete and not of appropriate quality, therefore impacting on the timescales of completion.</p> <p>With the Supervisory Body facing significant challenges in meeting the tight deadlines this will impact further on the timeline completion of applications.</p> | | <p>Potential risk of:</p> <ul style="list-style-type: none"> Patients are unlawfully deprived of their liberties. |
| Recommendations | | Priority |
| 3.1a | Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate. | High |
| Agreed Management Action | | Target Date |
| 3.1a | MCA/DoLS Team to review Standing Operating Procedure for DoLS Applications detailing timescales within the process. | 30/09/2024 |
| | | Head of Safeguarding Adults, MCA and DoLS (Responsible for all actions) |

| | | | |
|--|---|------------|--|
| | MCA/DoLS Team to provide key performance data regarding compliance of applications within timescales to the managing authorities. | 30/09/2024 | |
| | Provide the Managing Authority with opportunities to reflect on the quality of documentation through quarterly learning sessions to commence in Q2. As per action 2.1a Develop a Work Based Quality Improvement Plan based on themes and trends of the data analysis initially focussing on high referral areas to support reduced rejection rates at QA. Within the improvement plan identify measure for reduction in rejection rates and provide bi-monthly updates on progress and areas that require action with agreed escalation in place to managing authority. | 31/03/2025 | |
| | The Standing Operating Procedure for the completion of DoLS documentation to include criteria for triggering an escalation process for areas of concern i.e. high % of rejection at QA, low % compliance with agreed time frames. | 31/12/2024 | |
| | MCA and DoLS activity to become a standard item agenda at all Safeguarding Forum's to allow continuous oversight and awareness. | 30/06/2024 | |

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. |
|  | Unsatisfactory 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.



GIG
CYMRU
NHS
WALES

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

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Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: April 2024

Document reference: 4195A2024

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

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

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About this document

- 1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 7 May 2024.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|--|--|---|--------------------------------|
| Audit of the Health Board's Accounts: planning for 2023-24 (the Audit Plan) | Russell Caldicott, Interim Executive Director of Finance | Ongoing dialogue and meetings held to follow up on matters identified in our joint post project learning in preparation of the 2023-24 draft accounts and subsequent audit. Completion of planning and risk assessment stages of audit of the 2023-24 draft accounts. | We have issued our detailed audit plan to management for comment. The plan is to be considered by the Audit Committee on 7 May 2024. | May 2024 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|--|--|--|--------------------------------|
| | | | The audit of the 2023-24 financial statements will commence 7 May 2024. | |
| Charitable Funds 2022-23: <ul style="list-style-type: none"> • Planning • Audit of the Charitable Fund Financial Statements | Russell Caldicott, Interim Executive Director of Finance | <p>This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk.</p> <p>We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide his opinion on the financial statements of the Charitable Fund.</p> | <p>Audit work is complete.</p> <p>The Annual Report and Accounts have been approved by the Interim Executive Director of Finance and the Chair of the Charitable Funds Committee through the delegated authority given by the Charitable Funds Committee on 23 January 2024.</p> | April 2024 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|--------------|----------------|-------------------|--|--------------------------------|
| | | | The Auditor General for Wales is due to sign the audit opinion on 29 April 2024. | |

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---------------------------------------|--|--|----------------|--------------------------------|
| Follow-on work on board effectiveness | Carol Shillabeer – Chief Executive Officer | This work will consider the progress the Health Board has made in addressing the concerns on board effectiveness identified in the Auditor General's report in the public interest in February 2023. | Completed. | March 2024. |
| Structured Assessment 2023 | Carol Shillabeer – Chief Executive Officer | <p>Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work will review:</p> <ul style="list-style-type: none"> • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements. | Completed. | May 2024. |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|--|--|------------------|--------------------------------|
| | | <p>Please note that board effectiveness, which is normally part of our core structured assessment work, will be considered separately in the follow-on work that has been referenced above.</p> <p>In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.</p> | Drafting report. | July 2024. |
| All-Wales thematic on workforce planning arrangements | Jason Brannan, Deputy Director of Workforce & Organisational Development | This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address | Complete. | May 2024. |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|--|--|--|--------------------------------|
| | | short-, medium- and longer-term workforce needs. | | |
| All Wales thematic work on Unscheduled Care Arrangements: Phase 1 work on patient flow and discharge planning | Gareth Evans, Director of Therapies. | This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges. | Clearance: Draft report issued in February 2024. | July 2024. |
| Planned Care | Nick Lyons, Executive Medical Director | This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to | Planning | To be confirmed. |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|--------------|----------------|---|----------------|--------------------------------|
| | | consider waiting list performance and arrangements to improve elective waits. | | |

Other relevant publications

- 6 [Exhibit 3](#) provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

| Title | Publication Date |
|--|------------------|
| From firefighting to future-proofing – the challenge for Welsh public services | February 2024 |
| Board effectiveness follow-up – Betsi Cadwaladr University Health Board | February 2024 |
| Corporate Joint Committees – commentary on their progress | November 2023 |

Additional information

- 7 [Exhibit 4](#) provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

| Title | Publication Date |
|---|------------------|
| Audit Wales Annual Plan 2024-25 | April 2024 |

- 8 There are no relevant Audit Wales consultations currently underway.



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

Structured Assessment 2023 – Betsi Cadwaladr University Health Board

Audit year: 2023

Date issued: April 2024

Document reference: 40820A2024

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

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

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

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.
- 2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 3 The key focus of this work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:
 - Board transparency and effectiveness;
 - Corporate systems of assurance;
 - Corporate approach to planning, and
 - Corporate approach to financial management.Our separate review of board effectiveness is described in the following Background Context section, and our structured assessment work has not reviewed the Health Board's operational delivery arrangements.
- 4 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:
 - Model Standing Orders, Reservation and Delegation of Powers
 - Model Standing Financial Instructions
 - Relevant Welsh Government health circulars and guidance
 - The Good Governance Guide for NHS Wales Boards (Second Edition)
 - Other relevant good practice guidesWe undertook our work between January and February 2024. The methods we used to deliver our work are summarised in **Appendix 1**. We also provide an update in this report on the Health Board progress in addressing outstanding

recommendations identified in previous structured assessment reports in **Appendix 2**.

Background context

- 5 In February 2023, the Auditor General published a report in the public interest on Board Effectiveness at Betsi Cadwaladr University Health Board. The report described a worrying degree of dysfunctionality within the Board and wider senior leadership of the organisation. It concluded that the concerns identified were fundamentally compromising the ability of the Board to work effectively. One week after the publication of the Auditor General's report, the Health Board was escalated into special measures¹, and the Board's Independent Members all resigned.
- 6 Since February 2023 there has been a period of upheaval and change within the Board that initially saw the appointment of an interim Chair and three fixed term Independent Members, and then the recruitment of substantive Independent Members including a Vice Chair as the year progressed. In January 2024 the substantive appointment of the Chair was announced. There have also been changes in the make-up of the Executive Team since February 2023, most notably the announcement of the appointment of a substantive Chief Executive in November 2023.
- 7 In February 2024 we published the findings of our follow up work on Board Effectiveness. This work concluded that after a period of significant disruption during 2023, the board is in a more stable position and working relationships amongst senior leaders are more positive overall. However, the report indicated that there are still fundamental challenges to address, including building a high performing executive team, recruiting substantively to remaining posts on the board, and ensuring the new board demonstrates the unified and effective leadership that is needed to tackle the challenges the organisation faces.
- 8 The structured assessment findings contained in this report need to be considered in the context of, and alongside, our separate Board Effectiveness Follow-up report.

¹ Special Measures is the highest level of escalation on the NHS Wales escalation framework. Further information can be found via <https://www.gov.wales/sites/default/files/publications/2019-04/nhs-wales-escalation-and-intervention-arrangements.pdf>

Key findings

- 9 We found that **following significant challenges in 2023, the Health Board is more stable and in the process of strengthening key corporate assurance arrangements, but it needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand. The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations.**

Board transparency and effectiveness

- 10 **We found that following a period of disruption in 2023 described in our separate review of board effectiveness, the Health Board has re-established a full committee structure which in overall terms is operating effectively. However, there are opportunities to improve public accessibility to committee meetings and papers and address the backlog of policies that are due for review.**
- 11 Board meetings are accessible to the public both virtually and in-person, however, the public cannot currently observe most committee meetings. There is confusion regarding the deadline for making board and committee papers available to the public in advance of meetings. Confirmed and unconfirmed committee minutes are not all routinely uploaded to the Health Board's website. However, private Board and committee sessions are appropriately reserved for the most sensitive matters and private discussions are summarised in subsequent public meetings.
- 12 Whilst the Health Board has formal and up-to-date standing orders and standing financial instructions to support its Board and committee business, there remains a backlog of policies that are overdue for review.
- 13 Disruption in 2023 meant that some committees were stood down due to the temporary reduced number of independent members. However, in January 2024, following successful and ongoing recruitment of independent members, the Health Board reintroduced a full committee structure. Each committee is supported with a revised term of reference and cycle of business. Annual committee self-assessments are due to take commence early in 2024 and board and committee members regularly reflect on the effectiveness of meetings.
- 14 The Board and the Quality, Safety and Experience Committee continue to regularly hear from patients and the newly established People and Culture Committee has committed to receiving regular staff stories going forward.

Corporate systems of assurance

- 15 We found that the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is

needed to properly embed these new arrangements, to further develop the Board Assurance Framework, strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations.

- 16 The Board has approved a revised Board Assurance Framework (BAF). However, the BAF is still in early stages and requires further strengthening and linking to new strategic objectives, once developed. The Health Board's recently updated Risk Management Framework implementation is progressing, focussing on fewer higher priority risks that are linked to 2023-24 Annual Plan priorities and the special measures framework.
- 17 The Health Board recently introduced a new Integrated Performance Framework and Integrated Performance Report. Whilst the narrative set out in performance reports is improving, there is a need to focus more clearly on the action the Health Board is taking to improve performance and whether it is achieving the desired outcomes.
- 18 The Health Board is developing a new Quality Management System (QMS) as part of its requirement to comply with the Health and Social Care (Quality and Engagement) Act (2020). However, it has not provided assurance to the Board that it has reviewed the arrangements in place to support new requirements set out in the Act. Recent patient safety reports have shown poor performance in responding to complaints and incident investigations and many investigations are overdue. We have also noted a sudden and unexplained decrease in complaints in 2023-24, the reasons for which are currently unknown, but the Health Board is investigating.
- 19 The Audit Committee continues to regularly receive an audit tracker report but there is scope to provide further clarity and focus on whether actions taken are addressing the issues identified. The Health Board is taking steps to increase executive ownership of updates to the tracker, which should reduce the amount of time the Office of the Board Secretary is spending to quality assure the information on the tracker.

Corporate approach to planning

- 20 We found that the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand. There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts.
- 21 The Health Board's planning approach demonstrates a good understanding of its key strategic risks and challenges. It is now five years into its ten-year Living Healthier Staying, Well Strategy 2018-28. Acknowledging the longer-term consequences of the pandemic, many of the Health Board's services are struggling to meet demand and the position is not currently financially sustainable.

- 22 We have previously recommended that the Health Board needs to develop plans to support the implementation of its clinical strategy and that remains the case. While there are some limited examples of service developments and change, the Health Board's shorter-term approach to planning and programme delivery has not created a supportive environment for the level of transformation needed. The Health Board needs to create a plan for sustainable services and engage key stakeholders in its development.
- 23 In the Annual Plan 2023-24 the Health Board has agreed and aligned improvement initiatives, but reporting on progress is often task rather than impact or outcome focussed. This makes it difficult to see what difference it is making. The Health Board needs to think about the sustainable configuration of its services and engage its key stakeholders as part of the process ensuring an honest discussion on the challenges ahead.

Corporate approach to managing financial resources

- 24 We found that despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service models.
- 25 The Health Board met its duty to spend within its financial allocation over the three-year rolling period 2020-23 supported by additional strategic financial assistance from Welsh Government. However, the overall financial position remains a significant concern because of the underlying deficit. In the current financial year, it has received £82 million as part of a Welsh Government funding allocation to support targeted intervention as part of a 3½ year financial package. It received a further £34 million to support performance improvements, and in October Welsh Government allocated an additional £101.5 million to the Health Board to help respond to increasing financial challenges across NHS Wales. In total, as of December 2023, the Health Board received an additional £217.5 million non-recurring financial allocation in 2023-24. Despite this, it continues to forecast a £33 million deficit. The historic short-term approach to financial planning is driving a transactional approach to financial management. While there is a clear need for transactional financial control, there is also a need for a financial strategy to improve the position on the underlying deficit and that is linked to financially viable and sustainable clinical models.
- 26 The Health Board demonstrates reasonable approaches for scrutinising routine financial management arrangements and issues. However, given the financial issues identified in the audit of the 2021-22 and 2022-23 accounts, there is a need to fully assure the Board, through its committees, that the issues identified by Audit Wales, and the recommendations made in the subsequent EY investigation report are fully addressed.

Recommendations

- 27 Exhibit 1 details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**. **Appendix 2** provides an overview of progress against last year's recommendations.

Exhibit 1: 2023 recommendations

Recommendations

Transparency of board and committee business

- R1 Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings. **Paragraph 34**
- R2 The minutes for some committee meetings are missing from the website many months after the meeting date. This affects timely public access to committee discussions. The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. **Paragraph 35**

Changing trends in complaint numbers 2023-24

- R3 There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported. **Paragraph 68**

Recommendation tracking

- R4 Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion. **Paragraph 72**
- R5 Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales. **Paragraph 75**

Recommendations

Clinical engagement plan

- R6 More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand. **Paragraph 82**
-

Financial strategy

- R7 It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit. **Paragraph 98**
-

Monitoring progress against accounting issues

- R8 Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended. **Paragraph 104**

Detailed report

Board transparency and effectiveness

- 28 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.
- 29 We found that following a period of disruption in 2023 described in our separate review of board effectiveness, the Health Board has re-established a full committee structure which in overall terms is operating effectively. However, there are opportunities to improve public accessibility to committee meetings and papers and address the backlog of policies that are due for review.

Public transparency of Board business

- 30 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:
- meetings that are accessible to the public;
 - papers being made publicly available in advance of meetings;
 - business and decision-making being conducted transparently; and
 - meeting minutes being made publicly available in a timely manner.
- 31 **We found that the Health Board is increasingly demonstrating public transparency of board business, however there are opportunities to improve and standardise these arrangements for board committee meetings.**
- 32 In-person Board meetings take place in locations across North Wales on a rotational basis and are open for the public to observe. Meetings are broadcast live on YouTube with recordings made available to the public shortly after. The Board no longer addresses questions raised by the public during meetings, having reflected that questions submitted were based on a narrow view of patient experiences and subsequently commenced wider work on citizen engagement. However, The Board continues to respond to queries raised by the public outside of meetings.
- 33 Committee meetings are not live-streamed or recorded for the public to view, and the Health Board's website indicates that only two of the eight committees currently allow the public to observe meetings by request. Questions from the public can be submitted to all committees before meetings.
- 34 The Health Board's Standing Orders require Board and committee papers to be circulated to members and uploaded to the website ten days in advance of meetings. However, internally, a standard of seven days is reported against, and the public website cites that papers are published five days in advance of Board meetings and seven days for committee meetings (**Recommendation 1**). Breaches are routinely reported to the Audit Committee. The Health Board is clarifying its Board and committee meeting forward calendar, which also provides

the opportunity to provide clear paper publication dates which should help ensure timely submission of papers.

- 35 We have also noted inconsistencies in the timeliness of uploading unconfirmed and confirmed minutes after meetings. When we reviewed the website in January 2024, we found that minutes for some committee meetings were missing months after the meeting date². Given that committee meetings are not livestreamed, and recordings are not available to the public, it is important that minutes are added to the website soon after minutes to enable the public to see what has been discussed in meetings. To increase transparency further and ensure that the public has timely access to committee business, the Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business **(Recommendation 2)**.
- 36 The Board continues to appropriately reserve private Board and committee sessions for sensitive and commercial matters only. However, there is scope to clarify the rationale on report coversheets to explain why items are considered in private. The Health Board appropriately reports a summary of matters discussed in private in the subsequent public meeting.
- 37 As discussed in more detail in our Board Effectiveness Follow-up report 2024, we have observed more open and honest discussions in recent public Board and committee meetings.

Arrangements to support the conduct of Board business

We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
 - formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
 - formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.
- 38 We found that **whilst the Health Board has formal and up-to-date standing orders and standing financial instructions to support its Board and**

² At the time of our fieldwork, confirmed minutes for the Remuneration Committee had not been uploaded since July 2023 and there were no confirmed minutes for the Audit Committee since August 2023.

committee business, there remains a backlog of policies that are overdue for review.

- 39 The Board, supported by the Audit Committee regularly and appropriately reviews its Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions. They were most recently updated in November 2023, but the most recent versions are not yet available on the Health Board's website.
- 40 The Board and its committees adopt good governance procedures at the beginning of meetings including requesting declarations of interest. The Audit Committee annually reviews the procedures for declaring, registering, and managing interests, gifts, and hospitality. Current registers for Board members are available on the Health Board's website but are not easily accessible. The Health Board launched a new system for recording declarations of interests, gifts and hospitality in August 2023. The new system, alongside focussed communication is positively resulting in an increase in declarations across the wider organisation.
- 41 The position relating to Health Board policies is more concerning; 84 (59%) of the Health Board's 143 policies are currently overdue for review. The Health Board's policy for the review and update of policies, is currently being reviewed and will set out a new process for ensuring written control documents are kept up to date with current legislation and other requirements. The revised policy for the review and update of policies has been discussed by operational groups and the Audit Committee. The Audit Committee expects to receive the final version of the policy alongside a plan to prioritise the backlog of policies overdue for review in March 2024 (**Appendix 2, R4 2022**).

Effectiveness of Board and committee meetings

We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework; and
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and

42 We found that **there is now a full Board committee structure in place, with each committee supported by a term of reference, cycle of business and a commitment to regularly review the committee effectiveness.**

43 As discussed in more detail within our Board Effectiveness Follow-up report 2024, Board and committee business was significantly disrupted by the events that took place early in 2023. The Health Board was placed in special measures and each of the Board's then independent members resigned. In the following weeks and

months, Welsh Government directly appointed an Interim Chair and a small number of interim independent members. The reduced independent member capacity necessitated a temporary reduction in the number of committees between March 2023 and January 2024, as described in Exhibit 2. The Board continued to satisfactorily discharge core duties during this time, including ensuring coverage of the key duties of committees that had been stood down. However, there was an inevitable impact on the available time for discussion in meetings, including discussions on strategic planning as well as more specifically opportunities to hear staff stories.

- 44 There have since been several substantive independent member appointments which has now enabled the full reinstatement of the Board’s committees. Each committee has an up-to-date terms of reference and cycle of business³ that align to the Health Board’s strategic priorities and key risks.

Exhibit 2: changes to committee structures and meetings during 2023

| Committees that were stood down in February 2023 | Committees that continued to meet during 2023 | New/adapted committees established in January 2024 |
|---|--|---|
| Partnerships, People and Population Health Committee | Audit Committee, | Planning, Population Health and Partnerships Committee |
| Mental Health and Capacity Compliance Committee | Performance, Finance and Information Governance Committee, | Mental Health Legislation Compliance and Capacity Committee |
| | Quality, Safety and Experience Committee, | People and Culture Committee |
| | Remuneration Committee | |

³ The cycle of business is an annual calendar of core agenda items for a committee.

| Committees that were stood down in February 2023 | Committees that continued to meet during 2023 | New/adapted committees established in January 2024 |
|--|---|--|
| | Charitable Funds Committee ⁴ | |

- 45 Each committee chair provides a high-level summary of key decisions and matters considered during meetings to the Board. We understand that the Health Board intends to establish a committee chairs group to enable cross-referral of issues and inform meeting agenda setting.
- 46 The Board and its committees regularly reflect on the effectiveness of meetings and are planning to commence annual reviews of committee effectiveness early in 2024. Following the challenges and reshaping of the Board in 2023, the Health Board is in the process of developing a formal board development program to start early in 2024.

Board commitment to hearing from patients/service users and staff

- 47 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:
- The Board using a range of suitable approaches to hear from patients/service users and staff.
- 48 We found that **the Board’s arrangements for hearing directly from patients is improving, and it is planning to increase opportunities to hear directly from staff through service visits and hearing staff stories at People and Culture Committee meetings.**
- 49 The Board continues to receive patient stories at each meeting. During 2023, patient stories covered a range of services and included recordings of patients speaking about their experiences. The Health Board recently introduced its citizen experience report, which at the January 2024 Board meeting, generated good and open discussion on the quality of services from a patient’s perspective and was

⁴ The Charitable Funds Committee was temporarily stood down between February and July 2023

helpfully enhanced with feedback from Llais⁵. The Quality, Safety and Experience Committee continues to receive patient stories which are also summarised in its annual report and help to set the tone of its meetings. However, there has been an absence of staff stories at the Board and committee meetings over the last year. We understand that staff experience will be a regular feature of the People and Culture Committee following its establishment in January 2024.

- 50 Informal visits by Board members to a variety of service areas were held during much of 2023 to enable them to hear directly from patients and staff. However, the number of visits by each Board member varied due to differences in geography and capacity. However, by October 2023, the Health Board began to organise more formal service visits as part of the Board's development programme. It is adopting a targeted approach by linking the type and location of visits to current strategic risks and priorities. For example, prior to the Board's consideration of the Health Board's 2023-24 winter plan, the Board visited Ysbyty Gwynedd's Emergency Department and the Same Day Emergency Care facility to inform their understanding of key issues and barriers.

Corporate systems of assurance

- 51 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.
- 52 We found that **the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is needed to properly embed these new arrangements, to further develop the Board Assurance Framework, strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations.**

Corporate approach to overseeing strategic and corporate risks

- 53 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks. We were specifically looking for evidence of:
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
 - the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;

⁵ Llais is a national, independent body to give the people of Wales a stronger voice in health and social care services.

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

- 54 We found that **the Health Board has made progress revising its BAF and risk management arrangements, but it needs clear strategic objectives to align strategic risks to, and a stronger focus on the impact of actions it takes to mitigate risks.**
- 55 The Audit Committee approved the new BAF in November 2023. Given that the Health Board did not set strategic objectives in 2023-24, the BAF has been aligned to the nineteen priorities set out in its 2023-24 Annual Plan. The Board recognises the clear need to set longer-term strategic objectives and intends to do so during 2024-25. When devising its new strategic objectives, the Board should also review its well-being objectives to ensure compliance with the Well-being of Future Generations Act 2015⁶, noting that the Health Board has not reviewed its well-being objectives since 2018. Our work also found scope to strengthen the BAF to better articulate some strategic risks, by ensuring controls and lines of assurance are robust and mitigating actions are designed to have impact. The Board should also ensure that the BAF becomes a live and embedded approach for providing assurances to the Board and its committees and a tool for shaping and informing meeting agendas.
- 56 The Board approved its updated Risk Management Framework in September 2023. The framework is supported by key policies and clear processes. However, we note that underpinning arrangements including risk management training are still in development. During 2023, the Health Board revised and rationalised its corporate risk register focussing on the key corporate risks which impact on the achievement of the Board's priorities and referencing the Special Measures work where relevant. This rationalisation should usefully provide more time for committees to focus on the highest scoring risks. The approach also incorporates the Board's recently agreed risk appetite which was the focus of a board development session during summer 2023.
- 57 The Audit Committee is appropriately overseeing the Health Board's BAF and risk management framework. The Board and its committees routinely discuss the BAF and risk registers in their meetings, but there remains a need to focus more on the

⁶ Public bodies subject to the well-being duty in the Well-being of Future Generations Act 2015, are required to review their well-being objectives annually as part of annual reporting duties. In addition, in July 2023, the Minister for Social Justice set out the requirement for organisations to review their well-being objectives as soon as possible after April 2024, following the introduction of the Social Partnership and Public Procurement (Wales) Act 2023 and the resulting change made to a national well-being goal.

impact that actions are having to address risks. If mitigating actions are not having the desired impact, there will be a need to change the Health Board's approach for managing the risk (**Appendix 2, R1 2022**).

Corporate approach to overseeing organisational performance

- 58 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:
- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
 - the Board and committees providing effective oversight and scrutiny of organisational performance.
- 59 We found that **the Health Board is making improvements to its performance management framework and performance reporting, but there needs to be a greater focus on reporting the impact of actions the health board is taking to improve performance.**
- 60 The Board approved the new Integrated Performance Framework 2023-24 in September 2023. The framework outlines roles and responsibilities across the organisation and internal escalation arrangements. The Health Board has, however, recognised that the framework could be strengthened in some areas, including closer alignment to the Special Measures framework.
- 61 The Health Board has also revised its Integrated Performance Report (IPR), and its development was informed by engagement with executive groups and committees. The January 2024 IPR highlights several concerning performance trends and missed targets. These include ambulance handover times; Emergency Department waits and Referral to Treatment waits and waits for some mental health and ophthalmology services.
- 62 Board members have recognised some improvement in the reporting of performance, including more succinct narrative focusing on key concerns and emerging risks, and greater use of analysis tools such as Statistical Process Control (SPC) charts. Our analysis continues to indicate a need to focus on summarising the action the Health Board is taking to improve performance and whether that action is achieving the desired outcomes (**Appendix 2, R2 2022**).

Corporate approach to overseeing the quality and safety of services

- 63 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

- 64 We found that **the Health Board is taking action to implement a quality management system, but has not provided assurance to the Board that the required arrangements under the Duties of Quality and Candour are in place or progressing. In addition, timeliness of responses to incidents and complaints remains a concern and the reason for the significant drop in complaints in the first half of 2023/24 needs to be explained.**
- 65 Disruption to Board and committee business during 2023 meant that the Board has not received assurance that the organisation has reviewed its corporate arrangements for delivering the requirements under the Health and Social Care (Quality and Engagement) Act (2020) (the Act). We are aware that the Health Board is progressing work on a Quality Management System in line with requirements set out in the Act, which should be in place by April 2024. The revised arrangements will include a new quality dashboard and a learning portal to capture and analyse incidents and complaints and share learning.
- 66 The Quality, Safety and Experience Committee's regular patient safety report sufficiently details incidents and never events, highlighting actions taken on areas of concern, such as healthcare acquired pressure ulcers. Health Board reporting indicates that it has a high number of overdue complaints and incident investigations which need progressing. There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to 2022-23, which the Health Board is currently investigating, at the time of reporting, this had not been highlighted to the Quality, Safety and Experience Committee (**Recommendation 3**).
- 67 The Quality, Safety and Experience Committee's regulatory and legal report covers work of regulators including Healthcare Inspectorate Wales, the Health and Safety Executive, the Coroner and the Public Services Ombudsman for Wales (PSOW). The report provides the committee with a summary of work and briefly reassures the committee that actions are in place to address concerns and respond to requests from regulators. However, the information contained within the report is of a very high-level. There are opportunities for the report to demonstrate more clearly how it is implementing learning from these incidents, as well as embedding those lessons across the organisation. It is positive that the Health Board has taken action to ensure the accuracy of its reporting figures for complaints from the PSOW (**Appendix 2, R3 2022**).

Corporate approach to tracking recommendations

We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **whilst there is regular oversight of the audit tracker by the Audit Committee, and steps are being taken to strengthen executive ownership of tracker updates there is a need for clearer commentary on the impact of actions in response to recommendation and to strengthen recommendation monitoring in other committees.**

69 During 2023, the Health Board has seen new recommendations being added to the audit tracker at a faster pace than it has been able to close previous recommendations. In addition, we note that recommendations made in our 2023 reports have not been added to the tracker⁷

70 The Audit Committee continues to regularly receive the audit (**Recommendation 4**). tracker and accompanying summary report. While the audit tracker now contains an improved level of detail on management's rationale for recommending the closure of actions, the narrative tends to focus on tasks completed. This means committee members are not receiving adequate assurance that actions taken to close existing recommendations have achieved the desired effect and resolving the issues identified in the original audit report (**Appendix 2, R5 2022**).

71 The Office of the Board Secretary currently spends a significant amount of time quality assuring information provided by directorate to update the tracker. Greater executive ownership of these updates is needed, and we understand that, future submissions to the Audit Committee will require sign-off from the Executive Team.

72 We also noted that the approach for monitoring progress of recommendations by other committees needs strengthening. Beyond the Audit Committee, committees do not receive regular recommendation tracking reports, nor do they always receive routine assurance on progress made to address regulator recommendations. The Health Board should introduce effective committee oversight for monitoring progress against recommendations made by external review bodies. This includes strengthening existing mechanisms, such as the regulatory and legal report discussed in paragraph 69. Oversight should include all relevant regulators and inspectors, including but not necessarily limited to Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the PSOW (**Recommendation 5**).

⁷ This includes recommendations made in our 2023 Structured Assessment and our 2023 follow-up report on Follow-Up Outpatient Services.

Corporate approach to planning

- 73 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.
- 74 We found that **the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand. There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts.**

Corporate approach to producing strategies and plans

We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - an appropriate Board approved long-term clinical strategy;
 - appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
 - the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.
- 75 We found that **despite the challenges that the Health Board has faced in the last year, its planning approach has helped identify short-term improvement activity. However, it needs to give greater thought to the development of sustainable future focused service models and configurations and ensure that key stakeholders and the public are engaged in the process.**
- 76 The Health Board is five years into its Living Healthier, Staying Well Strategy 2018-28. Its improvement priorities cover a breadth of services within the Health Board's remit, including providing care closer to home, supporting mental health and well-being, and tackling health inequalities. Whilst the Health Board is now over half-way through the delivery of its strategy, performance in many areas is off target, there is a growing underlying financial deficit, and the longer-term outlook may see healthcare demand growing further⁸.

⁸ Analysis of Health Board demand over the last decade show growing levels of referrals and emergency department attendances, which now clearly exceed pre-pandemic levels.

- 77 Alongside the Living Healthier, Staying Well Strategy, the Health Board's 2022 clinical strategy, demonstrates a good understanding of the strategic opportunities and challenges that the organisation faces. While the clinical strategy provides logical high-level aims, it does not sufficiently set out the configuration of financially and clinically sustainable service models. Consequently, the enabling corporate strategies and plans for estate, digital and people, while reasonably focussed on addressing some key short-term challenges, are not sufficiently future focused to support the implementation of new, more sustainable care models. Last year we recommended that the Health Board needed to develop clinical strategy delivery plans to help provide the necessary clarity on service configuration. We understand that action in response to that recommendation is still in progress (**Appendix 2, R7 2022**).
- 78 Reconfiguring services to ensure they sustainably meet current and future population healthcare needs is likely to require some difficult decisions on the future shape and location, services. As such, the Health Board will need to effectively engage its key stakeholders, patients, and the **public (Recommendation 6)**. As discussed in **paragraph 57**, the Health Board is required to review its well-being objectives during 2024-25 in accordance with the sustainable development principle. This provides the opportunity to align well-being objective setting to organisational objectives and also ongoing strategy development.
- 79 The 2023-24 Annual Plan has provided some clarity on current improvement programmes and initiatives, but there is a need to become more strategic and balance short- and longer-term aspirations. The Health Board's short-term approach to planning in recent years, in lieu of an approvable integrated medium-term plan, has not sufficiently enabled the level of transformation or sustainable solutions needed as highlighted above.
- 80 In its July 2023 meeting, the Board approved the 2023-24 Annual Plan, following scrutiny at its previous meeting. Historically, the Health Board has demonstrated a good track record of committee-level scrutiny on annual plan development. Understandably this stopped when the Partnerships, People and Population Health Committee was stood down early in 2023. Nevertheless, the Board was able to adequately consider the annual plan before its approval.

Corporate approach to overseeing the delivery of strategies and plans

- 81 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART⁹ milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

82 We found that **temporary changes to the Board’s committee structure during 2023 reduced its ability to scrutinise the delivery of strategies and plans. Whilst the reinstatement of a full committee structure in early 2024 will rectify that, there is still a need to improve monitoring of the intended impact, outcomes and business benefits from the Health Board’s strategies and plans.**

83 The Health Board’s plans often contain reasonable high-level objectives and actions that set out a broad intent and are linked to its strategic risks and opportunities for improvement. In general, the Health Board’s plans are sufficiently timebound and clearly identify senior responsible officers. However, they rarely set out sufficiently measurable outcomes that would allow the Health Board to report and assess the outcome achieved and impact as a result of delivering the objectives and actions.

84 During 2022 and into early 2023, the Board maintained good oversight and scrutiny of the progress to deliver key strategic plans at its Partnerships, People and Population Health Committee. This included the Living Healthier, Staying Well Strategy 2018-28, the Clinical Strategy, Mental Health Strategy, Learning Disability Strategy, and People Strategy as well as scrutinising the delivery of annual plans. The Board has continued to oversee annual plan delivery progress, but since the Partnerships, People and Population Health Committee stood down in February 2023, the scrutiny of the implementation of other strategies and plans substantially reduced. The reintroduction of the Committee in January 2024 provides the opportunity to strengthen the scrutiny of plan development, delivery and success in achieving intended outcomes and impact.

Corporate approach to managing financial resources

85 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

86 We found that **despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service models.**

⁹ Specific, measurable, achievable, relevant, and time-bound

Financial objectives

- 87 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:
- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
 - the organisation being on course to meet its objectives and duties in 2023-24.
- 88 We found that **with the support of substantial additional Welsh Government financial assistance, the Health Board met its duty to spend within allocation over the three-year rolling period 2020-23. However, the overall financial position continues to present a significant risk and the Health Board is projecting that it will not achieve the year-end position expected by Welsh Government**
- 89 The Health Board has experienced longstanding financial challenges. In November 2020, as part of Welsh Government’s announcement to de-escalate the Health Board to ‘targeted intervention’¹⁰, the Health Board received an additional financial allocation worth £297 million. The additional allocation was split over the three-and-a-half-year period from October 2020 to April 2024. With this additional funding, alongside other in-year allocations and its savings delivery¹¹, the Health Board met its duty to spend within its funding allocation over the three-year period 2020-23. In respect of the financial year 2022-23, the Health Board met its duty to manage its spend within its £1.993 billion allocation¹², supported by additional financial assistance.
- 90 As in previous years, the Health Board did not meet its statutory duty to prepare a financially balanced three-year financial plan for 2023-26. Instead, it developed an annual plan for 2023-24, which set out a predicted financial year-end deficit of £134 million. During 2023-24 the Welsh Government provided additional financial support to all health boards to help alleviate pressures from COVID legacy costs and inflation, including energy costs. This resulted in the Health Board receiving £101.5 million from Welsh Government. This came with a conditional requirement to reduce the deficit within its annual plan by a 10% (equating to a need to work towards a “control total” deficit of £20 million at the end March 2024). In addition to the £101.5 million the Health Board has received £34 million performance improvement funding and final year’s £82 million funding from the £297 million targeted intervention allocation. In total, as of December 2023, the Health Board has received an additional £217.5 million for the financial year 2023-24. Despite this, the Health Board continues to report a forecast year-end deficit of £33 million.

¹⁰ [Betsi Cadwaladr University Health Board taken out of special measures | GOV.WALES](#)

¹¹ The Health Board achieved £18.4 million savings in 2020-21, £19.2 million savings in 2021-22 and £31.2 million savings in 2022-23.

¹² The Health Board underspent against its allocation by £0.389 million in 2022-23.

The Health Board's substantial reliance on additional non-recurring annual funding clearly demonstrates the scale of the challenge in bringing the Health Board to a balanced financial position.

Corporate approach to financial planning

- 91 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:
- clear and robust corporate financial planning arrangements in place;
 - the Board appropriately scrutinising financial plans prior to their approval;
 - sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
 - the Board appropriately scrutinising savings and cost improvement plans prior to their approval.
- 92 We found that **the Health Board's approach for financial planning is driving a transactional approach to financial management and while delivering some in-year savings this isn't significantly addressing the Health Board's underlying deficit. There is a clear need for a financial strategy to underpin medium- to long-term planning that fully considers growth in healthcare demand and supports financially sustainable clinical service models, whilst also reducing the underlying deficit.**
- 93 The approach for financial planning for 2023-24 was significantly affected by senior finance staff absence following the investigation into irregularities in the 2021-22 accounts¹³ and the need to secure interim leadership arrangements for the Finance Team. This resulted in the financial management team preparing a limited briefing which outlined anticipated cost pressures for review by the Performance, Finance and Information Governance committee in January 2023. Following this, the Board, at its first meeting with the new interim Board members, received only a high-level outline 2023-24 financial budget which it approved in March 2023. This was understandably a difficult period both for the financial management team and the recently appointed interim board members. The Board received and agreed the final financial plan as part of the 2023-24 Annual Plan in July 2023.
- 94 When considering the full 2023-24 Annual Plan, it is not clear whether the Health Board's improvement initiatives and aims set out in the plan are financially affordable. This suggests a need for a more integrated approach to financial planning. While the 2023-24 Annual Plan provides reasonable information on

¹³ [Auditor General qualifies his audit opinions on Betsi Cadwaladr University Health Board's 2021-22 Accounts | Audit Wales](#)

spend, financial pressures and risks, it is clear that there is a need for a financial strategy to help enable financially sustainable services (**Recommendation 7**).

- 95 In March 2023, the Health Board set out a requirement to achieve £38.7 million savings (inclusive of a £7 million stretch target) in 2023-24. By May 2023, the Health Board had revised this target down to £30.9 million (inclusive of a £5.7 million stretch target). The Health Board was initially slow to identify sufficient saving schemes but had made reasonable progress by December 2023. At this time, it had identified £25.6 million deliverable 'green' savings¹⁴ against the £30.9 million target. Having developed the saving schemes, the Health Board made slow progress to deliver them, having achieved only £12.8 million by October 2023. However, by December 2023, delivery of financial savings had improved to £17.5 million.
- 96 The Board and the Performance, Finance and Information Governance Committee both appropriately oversee and challenge the delivery of savings plans, although there is clearly a need for earlier sight of the development of savings plans. The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

- 97 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:
- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
 - the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
 - effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
 - the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.
- 98 We found that **there are reasonable corporate approaches for scrutinising routine financial management arrangements and issues. However, the Health Board needs to appropriately assure itself that the financial controls improvements identified in previous audits and independent reports are effectively and fully addressed.**

¹⁴ The Health Board assesses its proposed savings as "Red, Amber or Green". Those identified as green are considered deliverable within the financial year.

- 99 The Health Board has reasonable processes in place to ensure compliance with statutory instructions, and to report and challenge breaches. As set out in **paragraph 40**, the Standing Financial Instructions and Schemes of Delegation have been reviewed by Audit Committee and approved by the Board. The Health Board adopted the model Welsh Government Standing Financial Instructions with some minor tailoring to make them specific to the Health Board. The number of single tender waivers¹⁵ have started to reduce as a result of stronger management oversight and control (**Appendix 2, R10 2022**). The Audit Committee routinely reviews and scrutinises losses and special payments, breaches of standing orders, counter-fraud activities and the management of overpayments.
- 100 The Health Board is responding to the issues identified in our audits of the 2021-22 and 2022-23 accounts, as well as those identified in the EY review. However, progress to address these issues has been slower than intended. The Health Board prepared a financial control action plan, which covered some but not all of the EY recommendations. This was reported to the Audit Committee in May 2023, but is no longer reported to the Audit or Performance, Finance and Information Governance committees, and as of May 2023, the actions were not fully completed (**Recommendation 8**).

Board oversight of financial performance

- 101 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:
- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
 - the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.
- 102 We found that **the Health Board continues to have good arrangements for monitoring and scrutinising its in-year financial position. However, it needs to strengthen assurance reporting on the extent that actions it is taking to support financially sustainable services are making a difference.**
- 103 As set out in our 2022 structured assessment, there are regular financial reports to the Performance, Finance and Information Governance Committee and the Board. Reports are generally timely and transparent, providing good analysis on areas of spend, overspend and financial expenditure trends. The reports set out the short-term financial challenges and identify where there are specific financial concerns. Notwithstanding the challenges the Health Board is facing in delivering its savings plans, the separate report on financial savings provides good analysis of progress

¹⁵ A single tender waiver is used to allow procurements without a full tendering process and competition.

identifying and delivering savings schemes, the proportion of cash releasing schemes, and the extent that schemes are generating recurring savings.

- 104 The Health Board has a good understanding of the financial challenges set out within financial assurance reports. However, there is limited narrative on the mitigating actions, beyond the need to identify additional savings or strengthen accountability. The reports do not enable the reader to fully understand whether action taken to improve finances has been successful, nor the extent that the Health Board's approach to service transformation is helping to, or likely to put the organisation on a more sustainable financial footing. The Board and the Performance, Finance and Information Governance Committee have open and frank discussions on financial performance and is keenly aware that the Health Board approach to financial planning is not sustainable.

Appendix 1

Audit methods

Exhibit 3 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

| Element of audit approach | Description |
|---------------------------|--|
| Observations | We observed board meetings as well as meetings of the following committees: <ul style="list-style-type: none">• Board meeting: 28 September 2023; 30 November 2023; and 25 January 2024• Quality, Safety and Experience Committee: 27 October 2023• Performance, Finance and Information Governance Committee: 2 November 2023; and 22 January 2024• Audit Committee: 16 November 2023; and 12 January 2024 |

| Element of audit approach | Description |
|---------------------------|---|
| Documents | <p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none"> • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies. |

Interviews

We interviewed the following Senior Officers and Independent Members:

- Chief Executive Officer;
- Chair;
- Board Secretary;
- Chair of Audit Committee;
- Chair of Quality, Safety and Experience Committee;
- Chair of Performance, Finance and Information Governance Committee;
- Deputy Director of Quality;
- Head of Risk Management;
- Executive Director of Nursing and Midwifery;
- Executive Director Transformation, Strategic Planning, and Commissioning; and
- Interim Executive Director of Finance.

Appendix 2

Progress made on previous recommendations

Exhibit 4 below sets out the progress made by the Heath Board in implementing recommendations from previous structured assessment reports

| Recommendation from 2022 | Description of progress |
|---|---|
| <p><u>2021 Structured Assessment</u></p> <p>Financial reporting</p> <p>R1 Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.</p> <p>Planned completion date contained within original management response: 28 February 2022.</p> | <p>We will comment on progress for this recommendation as part of our review of our cost savings review, which we will publish later in 2024.</p> |

| Recommendation from 2022 | Description of progress |
|---|---|
| <p>Review and where needed, strengthen risk mitigating actions</p> <p>R1 Despite recent changes to the Health Board’s strategic and corporate risk arrangements, risk scores in some key areas are not decreasing. The Health Board should review the mitigating actions on the corporate risk register and Board Assurance Framework to ensure they are having the intended impact.</p> <p>Planned completion date contained within original management response: 28 September 2023.</p> | <p>In progress. The Health Board has reviewed and revised its Board Assurance Framework (BAF) and Corporate Risk Register (CRR), which the Audit Committee approved in November 2023. These assurance tools remain at an early stage of implementation. As such, it is too early to determine whether the changes are helping to drive improvements in the management and assurance to support the scrutiny of operational and strategic risks. There remains a need to focus more on the impact that actions to address risks are having.</p> |
| <p>Review of performance management assurance reporting</p> <p>R2 The Health Board is continuing to refine performance reporting into board and committees. However, there remain concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvements. The Health Board should improve its performance assurance reporting, focussing more on the impact of performance improvement actions.</p> <p>Planned completion date contained within original management response: 31 July 2023 with continued review.</p> | <p>In progress. The Health Board has revised its Integrated Performance Report (IPR) which was approved by the Board in November 2023. Members of the Board have recognised that the new reports demonstrate progress with more succinct narrative focussing on key concerns and emerging risks, as well as greater use of and training for analysis tools such as Statistical Process Control (SPC) charts. Our analysis shows that there remains scope to increase the report’s narrative on the impact of mitigating actions.</p> |

| Recommendation from 2022 | Description of progress |
|--|---|
| <p>Ensure accuracy of reporting Public Services Ombudsman for Wales figures</p> <p>R3 There have been discrepancies between the complaint figures reported by the Public Services Ombudsman for the Health Board and the Health Board's own figures within previous annual reports. While the Health Board rectified this in its 2021-22 annual report, the Health Board should ensure such discrepancies do not reoccur. The Health Board should validate and verify Public Service Ombudsman for Wales complaint numbers prior to inclusion in annual reports.</p> <p>Planned completion date contained within original management response: Completed at time of reporting (August 2023)</p> | <p>Complete. The Health Board instigated monthly meetings with the office of the Public Services Ombudsman for Wales to validate data to ensure accurate annual reporting.</p> |
| <p>Review Health Board policies</p> <p>R4 The Health Board has a significant number of policies overdue for renewal, which exposes the organisation to service and administrative risks. The Health Board should review and update Health Board policies, prioritising high importance policies first, including the policy on policies.</p> <p>Planned completion date contained within original management response: September 2023</p> | <p>In progress. The revised policy on policies has been discussed by operational groups and the Audit Committee along with a proposed plan for addressing the Health Board's backlog of policies. The Health Board anticipates that it may take 18 months to complete.</p> |

| Recommendation from 2022 | Description of progress |
|---|---|
| <p>Review audit recommendation tracker</p> <p>R5 The audit recommendation tracker and report in their current format provide limited detail, particularly around actions considered complete. The Health Board should work with Audit Committee members to review the format of the audit tracker and report to ensure it provides sufficient information to provide assurance.</p> <p>Planned completion date contained within original management response: September 2023</p> | <p>In progress. The Health Board has revised the format of its audit tracker since last year. There is an improved level of detail in relation to actions which are recommended for closure. However, the information is more focussed on actions taken rather than reporting if the original recommendation has been addressed. This can sometimes lead to false assurance that the recommendation is complete.</p> |
| <p>Implementation of the new operating model</p> <p>R6 The Health Board should complete the implementation of the new operating model as a matter of urgency, particularly in respect of recruiting substantial post holders and reducing reliance on interim appointments.</p> <p>Planned completion date contained within original management response: Continued review required.</p> | <p>In progress. The Health Board has recruited substantively to several senior posts, reducing its reliance on interim roles. The Health Board intends to reflect on the implementation of the operating model during 2024.</p> |

| Recommendation from 2022 | Description of progress |
|--|--|
| <p>Develop a supporting clinical delivery plan</p> <p>R7 The Health Board has developed a clinical strategy for its services, however, there is lack of detail on how it will be implemented. The Health Board should develop supporting clinical delivery plan/plans and delivery structures to shape and implement sustainable service models. Clinical plans should inform workforce, estate, financial resource, and digital services planning.</p> <p>Planned completion date contained within original management response: Quarter 4 2023-24</p> | <p>In progress. The Health Board will be taking stock of strategic commitments as part of the revised approach to planning. Given service pressures and related performance, potential for growth in demand in the medium- to long-term, and the underlying financial deficit, there remains a clear need for the Health Board to prepare financially sustainable clinical strategy delivery plans that set out new configurations of services.</p> |
| <p>Reporting on the impact of value-based healthcare initiatives</p> <p>R8 We found limited evidence of how the Health Board is implementing value-based healthcare operationally to its services to maximise value and efficiency. The Health Board should ensure reporting on its value-based healthcare programme focusses on the outcomes achieved.</p> <p>Planned completion date contained within original management response: December 2023 with continued review</p> | <p>In progress. The Health Board indicates that its approach will be considered as part of its Planning Framework. Specific projects including on Lymphoedema & Cellulitis and Patient Reported Outcome Measures led follow up arthroplasty are underway. There remains a need to assess and report on the impact and outcomes of the initiatives.</p> |

| Recommendation from 2022 | Description of progress |
|--|---|
| <p>Urgently implement financial recovery approaches to strengthen the financial position</p> <p>R9 As of January 2023 the Health Board is off-track with its current savings plan and is slow to progress the savings plan for 2023-24. The Health Board should:</p> <ul style="list-style-type: none"> • prepare appropriate financial recovery programmes as a matter of urgency for both the remainder of this, and the next financial year. • review options for estate and service disinvestment (i.e., where services are not demonstrating sufficient patient impact and outcomes). • introduce stronger reporting and oversight of the medium-term financial position, financial strategy and recovery approaches. • target digital investments on areas of clear business benefits, i.e., where digital can be used to release service efficiency and/or quality gains elsewhere. <p>Planned completion date contained within original management response: Completed at time of reporting (August 2023)</p> | <p>In progress. From a slow start, the Health Board improved the identification and delivery of saving schemes for 2023-24. Although forecast to meet the revised lower target of £25.2 million, these fall short of the original savings target identified at the beginning of the year.</p> <p>There remains a need for a stronger focus on financial strategy which links to options for estates and service disinvestment in instances where value and efficiency is not demonstrated. The Health Board has improving transparency of financial reporting, but there needs to be a stronger focus on the medium-term financial position linked to financial strategy and recovery approaches.</p> <p>Limited capital is affecting investment in digital and there continues to be a need to target digital investments where this would release service efficiency gains and transformation.</p> |

| Recommendation from 2022 | Description of progress |
|--|--|
| <p>Introduce stronger financial planning and control to reduce reliance on single tender waivers</p> <p>R10 The Health Board has a track-record of substantial and growing use of single tender waivers. The Health Board should improve procurement planning and strengthen single tender waiver financial controls.</p> <p>Planned completion date contained within original management response: Completed at time of reporting (August 2023)</p> | <p>Complete. The Health Board has strengthened single tender waiver controls which has reduced the overall extent of their use and associated expenditure committed to through waivers.</p> |
| <p>Ensure effectiveness of staff well-being services</p> <p>R11 The Health Board has introduced a programme of services to support staff wellbeing. However, it is not currently undertaking sufficient evaluation to ensure these are meeting the needs of staff. The Health Board should evaluate the impact of its staff wellbeing services to inform future investment decisions.</p> <p>Planned completion date contained within original management response: Quarter 2023-24</p> | <p>We will review the progress against this recommendation later in 2024 as part of our next structured assessment review.</p> |

| Recommendation from 2022 | Description of progress |
|--|--|
| <p>Improve performance and financial oversight for digital and estates</p> <p>R12 There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should:</p> <ul style="list-style-type: none"> • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation. | <p>In progress. The Health Board has indicated that it will seek to address the recommendation through the implementation of the new Planning Framework and Integrated Performance Framework.</p> |

Appendix 3

Organisational response to audit recommendations

Exhibit 5: Betsi Cadwaladr University Health Board response to our audit recommendations

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|---|-----------------|----------------------------------|
| R1 | Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings. | <p>Agreed.</p> <p>The Health Board has confirmed the standard target date of Board and Committee papers will be 7 days' notice in advance of meetings.</p> <p>The Director of Corporate Governance will communicate this timescale to all Board and Executive Team Members to ensure there is no confusion of timescales.</p> | End April 2024 | Director of Corporate Governance |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|--|-----------------|---|
| R2 | The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. | Agreed. The Director of Corporate Governance will review the current process and the Standing Operating Procedure for Board and Committee meeting and agree this with the Board. | 31 May 2024 | Director of Corporate Governance |
| R3 | There has been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported. | Agreed. The Executive Director of Nursing & Midwifery with the Director of Digital, Data and Technology will lead work to check the data quality. that information is still being received and no specific reason for this drop has been confirmed. The Health Board has also committed to the development of a Quality Management System that will enable learning from complaints / feedback to be fully understood and reflected in the Health Board's quality planning | 30 June 2024 | Executive Director of Nursing & Midwifery |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|--|-----------------|----------------------------------|
| | | <p>process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.</p> | | |
| R4 | <p>Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion.</p> | <p>Agreed. A process has been agreed with the Executive Team and Chair of the Audit Committee which includes Audit recommendations being received at Executive Team Meetings (bi-monthly) prior to risks being received for formal closure at Audit Committee. This process will allow for Executive Team to check that Audit Wales recommendations are added to the audit trackers in a timely fashion before updates are received at the Audit Committee for assurance. This allows Audit Wales colleagues (who attend Audit Committee) to check compliance with this process.</p> | 31 May 2024 | Director of Corporate Governance |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|--|-----------------|---|
| | | <p>Whilst this process has been agreed and has commenced a further cycle of it needs to have taken place before this recommendation can be evidenced as being effective and complete.</p> | | |
| R5 | <p>Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.</p> | <p>Agreed.</p> <p>A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non-audit bodies. This includes QSE Committee and a People and Culture Committee.</p> <p>The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinate and have appropriate oversight at Committee and where appropriate Board level.</p> | 31 July 2024 | <p>Director of Corporate Governance</p> <p>Executive Medical Director and Executive Director of Nursing & Midwifery</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|---|---------------------------|---|
| | | <p>The Health Board has also committed to the development of a Quality Management System that will enable learning from regulatory reports to be fully understood and reflected in the Health Board's quality planning process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.</p> | | |
| R6 | <p>More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand.</p> | <p>Agreed.</p> <p>The Health Board recognises the importance of this recommendation. As part of the priority actions for 2024-25, as laid out in the Three Year Plan, the Health Board has planned significant actions that together progress this recommendation.</p> <p>The following actions will be taken forward:</p> | End of Quarter 1, 2024-25 | <p>Executive Director of Transformation, Strategic Planning & Commissioning</p> <p>with support from Executive Director of Population</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|--|-------------------------|---|
| | | <p>During 2024-25 the Health Board will commence the development of a new Health Board strategy and Clinical Services plan. To support this, priorities are already identified to maximise the effect of the stakeholder engagement being planned to support this. These specific priority areas include general work to improve the Health Boards approach to citizen engagement, being a Good Partner, engaging with the national Value and Sustainability Board to incorporate learning from other organisations within NHS Wales, and engaging with clinicians within and outside of the Health Board.</p> | | <p>Health and Director of Partnerships, Engagement and Communications</p> |
| R7 | <p>It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially</p> | <p>Agreed. The Board approved the financial plan in May 2023 with the Annual Plan approved at the end of June 2023</p> | <p>End of July 2024</p> | <p>Executive Director of Finance</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|--|--------------------|-------------------------------|
| | <p>affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit.</p> | <p>following agreement with Welsh Government.</p> <p>The HB developed revised plans in year with the expressed intention of balancing improvements in quality and performance within an affordable financial envelope. The focus from close of 23/24 financial year and moving into 24/25 and beyond has been to endorse a value and sustainability approach to delivery of improvements for staff, patients and visitors that will also result in a sustainable financial for future health care.</p> | | |
| R8 | <p>Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and</p> | <p>Agreed.</p> <p>Progress reports will be schedule of part of the Audit Committee Programme of work.</p> | End of August 2024 | Executive Director of Finance |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|-------------------------|-----------------|---------------------|
| | the subsequent EY review has been slower than intended. | | | |



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Review of Workforce Planning Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2022

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Summary report

Introduction

- 1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists ([A Picture of Healthcare, 2021](#)). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their [2022 Nursing in Numbers](#) analysis. In addition, the social care sector, which is complementary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.
- 2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.
- 3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:
 - workforce age profile, retirement, and pension taxation issues;
 - shifts in attitudes towards full and part-time working;
 - developing home grown talent and the ability to attract talent from outside the country into Wales; and
 - service transformation which can change roles and result in increasing specialisation of roles.
- 4 Betsi Cadwaladr University Health Board (the Health Board) developed its 2022-2025 People Strategy and Plan (the Strategy) during 2021. The Board approved the Strategy in May 2022 which it developed as part of the Health Board's 'Stronger Together'¹ programme.
- 5 In February 2023, the Minister for Health and Social Services returned the Health Board to 'special measures', the highest category of escalation on the Welsh Government's Escalation and Intervention framework. A small team of external HR experts completed a review (Assessment of key areas of workforce agenda) as

¹ This is a three-year system and organisational development route map to enable the Health Board to better meet its purpose and goals through the alignment of its process, behaviours, and structures.

part of the initial special measures 90-day cycle. That review focussed on Leadership, Culture and staff engagement, employee wellbeing, workforce planning, workforce policies, and employee relations. The Health Board is incorporating the recommendations from the review into its special measures approach.

- 6 The key focus of our review has been on whether the Health Board's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Health Board's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering, consultant job planning, and operational deployment of agency staffing, fall outside the scope of this review.
- 7 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 8 Overall, we found that **whilst the Health Board has set out a reasonably clear and ambitious workforce strategy, it needs to significantly strengthen its implementation plans along with the organisation's workforce planning capacity and capability. Arrangements to oversee the delivery of strategic and operational workforce aims also need to be strengthened.**

Key workforce planning challenges

- 9 The Health Board is facing significant workforce challenges across a range of services and professions, causing greater workload pressures on existing members of staff. The workforce indicators presented in **Appendix 2** highlight that despite the Health Board increasing its workforce numbers over the past decade, it still faces serious recruitment and retention challenges, which threaten the stability of services. The Health Board's staff turnover (10%) and sickness rates (6%) present ongoing challenges. This caused a sharp rise in the use of agency staff in 2022-23 which cost the Health Board £72 million, further exacerbating an already pressured financial situation.

Strategic approach to workforce planning

- 10 **The Health Board has set a reasonably clear strategic workforce vision, however, there is a need for a clear plan to deliver the People Strategy and the Health Board's workforce planning approach needs to be strengthened substantially.**
- 11 The Health Board's People Strategy is ambitious, but there needs to be a realistic and deliverable medium-term implementation plan with clear priorities to effectively support its delivery. The Health Board has an improving understanding of current workforce capacity and is improving the availability of operational workforce

information. However, the Health Board clearly needs to strengthen how it models and plans its workforce to ensure its services are sustainable in the medium and long term. The Health Board is collaborating proactively with external stakeholders to find shared solutions to workforce challenges. And to help it tackle some key workforce challenges, it is now starting a new Culture, Leadership and Employee Engagement programme and implementing a new people team model to build stronger internal relationships, strengthen culture and behaviours, and ensure effective staff engagement.

Operational action to manage workforce challenges

- 12 **The Health Board does not have sufficient capacity and capability to allow it to effectively support workforce planning. While its teams understand and are responding to operational key workforce challenges, the scale of the problem has meant that the level of workforce risk that the organisation is facing has not notably reduced.**
- 13 The Health Board is strengthening its 'people team' with the introduction of people business partners. However, it does not yet have sufficient resources to support workforce planning at corporate or service levels. The Health Board currently has just under 18,000 whole time equivalent staff. Between 2017-18 and 2022-23, its total annual pay costs increased by 48% to £1.04 billion. If historical growth in staffing levels continue to grow, overall workforce costs are very unlikely to be sustainable into the long term. The Health Board must sufficiently invest in its corporate and devolved workforce planning capacity and capability to ensure efficient and affordable staffing and service models in the medium term.
- 14 The Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions, nevertheless, the scale of the workforce challenges means that mitigating actions are having minimal impact on reducing workforce risk. There are some good examples of teams proactively seeking to address workforce challenges at an operational level through a range of recruitment, retention, and development activities. However, significant challenges remain.

Monitoring and oversight of workforce plan/strategy delivery

- 15 **The Health Board's workforce strategy or plan is not sufficiently supported by robust monitoring, oversight, and review.**
- 16 Operational workforce information has been appropriately scrutinised by the Health Board's Performance, Finance, and Information Governance Committee. Since February 2023, a shortage of Independent Members had resulted in the Board standing down its Partnerships, People and Population Health Committee. This reduced the formal oversight and assurance on delivery of the People Strategy and related work. When the Health Board last reported in January 2023, there clearly was a need to strengthen the focus on the overall pace of progress of People

Strategy delivery and focus more on the impact of the actions it is taking to deliver it. The Health Board has now introduced a new People and Culture Committee that assumes responsibility for workforce strategy oversight.

Recommendations

17 **Exhibit 1** details the recommendations arising from this audit. These include our assessment of priority. The Health Board recently received an external HR experts report called 'Assessment of key areas of workforce agenda'. This included 30 recommendations covering leadership, employee wellbeing, workforce planning and employment policies. However, we have indicated in **Recommendation 1** below that the actions to deliver those 30 recommendations should be incorporated into a prioritised People Strategy implementation plan. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

| Recommendations | |
|---|---|
| Delivery of the People Strategy | |
| R1 | The Health Board should strengthen and further develop their current implementation plan for delivery of the People Strategy that: <ul style="list-style-type: none">a) Sets out clear goals and targets and prioritised activities, with clear delivery timelines and accountabilities. (High priority)b) Incorporates actions to deliver the 30 recommendations made in the Assessment of key areas of workforce agenda. (High priority) |
| Service level workforce planning | |
| R2 | In order to better understand its current and future workforce requirements the Health Board should: <ul style="list-style-type: none">a) Undertake analysis to understand its current workforce requirement and future service models to determine the workforce needed to create sustainable and efficient acute and community services. This will require:<ul style="list-style-type: none">– forecasting of service demand;– service modelling; and– analysis of capacity requirements, by specialism and profession. (High priority)b) Ensure there is sufficient capacity and capability within the Health Board to support effective workforce planning; this should include identifying |

Recommendations

where scope exists to re-deploy existing staff resources and ensure there are clearer remits within existing job specifications. **(High priority)**

Support and training

- R3 The Health Board should develop an evaluation framework to measure the success of the workforce planning training programme it intends to roll out. The evaluation of the training programme should incorporate an early assessment of whether the training is achieving its intended aims. **(Medium priority)**
-

Exit and pulse surveys

- R4 To better understand issues affecting staff turnover the Health Board should:
- a) Develop an approach to increase exit survey response rates and ensure feedback from the surveys informs retention activities. **(Medium priority)**
 - b) Conduct regular pulse surveys/stay interviews to gauge how staff are feeling and identify any improvements it can make to support retention and manage staff turnover. **(Medium priority)**
-

Monitoring and oversight

- R5 the health board should strengthen its approach to monitoring delivery of the people strategy and associated implementation plans and workforce programmes. the monitoring approach should have a focus on whether the strategy is achieving its desired aims and outcome, include engagement with the new people and culture committee and incorporate implementation of the recommendations from the external 'assessment of key areas of workforce agenda review'. **(Medium priority)**

Detailed report

Our findings

18 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- the Health Board's approach to strategic workforce planning (**Exhibit 2**);
- operational action to manage workforce challenges (**Exhibit 3**); and
- monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: The Health Board's approach to strategic workforce planning

This section focusses on the Health Board's approach to strategic planning. Overall, we found that **the Health Board has set a reasonably clear strategic workforce vision, however, there is a need for a clear plan to deliver the People Strategy and the Health Board's workforce planning approach needs to strengthen substantially.**

| What we looked at | What we found |
|--|--|
| <p>We considered whether the Health Board's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which:</p> <ul style="list-style-type: none">• identifies current and future workforce challenges;• has a clear vision and objectives; | <p>We found that while the Health Board's People Strategy sets a reasonably clear ambition, there is a need for a clear and resourced plan (or plans) to effectively support delivery of it.</p> <p>The Health Board clearly articulates its workforce challenges in its People Strategy including a need to support flexible working, the aging workforce, supporting career progression supporting new service models and resolving recruitment and retention issues. The People Strategy appropriately supports the ambitions set out in the National Workforce Strategy for Health and Social Care². It also</p> |

² 'The Workforce Strategy for Health and Social Care' is a ten-year strategy launched in October 2020 by HEIW and Social Care Wales.

| What we looked at | What we found |
|--|---|
| <ul style="list-style-type: none"> • is aligned to the organisation’s strategic objectives and wider organisational plans; • is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care; and • is supported by a clear implementation plan. | <p>appropriately aligns to some relevant national legislation, although there is insufficient consideration of the Well-being of Future Generations Act requirements³.</p> <p>The People Strategy includes a series of ambitious goals and priorities for delivery between April 2022 and March 2025. It sets out a high-level thematic approach to deliver its ambition. The themes include ‘our way of working’ which seeks to improve culture, strategic deployment (resource planning and performance management), how Health Board will improve the way it organises itself, making the ‘best of our abilities’ through workforce development and supporting improvement and transformation. However, its ‘one size fits all’ approach needs to also allow appropriate variation to help solve local challenges. For example, the West Integrated Health Community⁴ struggles to recruit to some services because of its rural location, whereas East Integrated Health Community competes for staff with English health bodies. Although the resulting outcome (ie shortage of staff) is the same, there will be a need for tailored solutions because the causes of the problem are different.</p> <p>While the Health Board’s People Strategy is reasonably clear and setting out what it is seeking to achieve, its plan to deliver it is insufficient. In particular, it is missing a clear and resourced programme delivery approach, medium-term priorities, clear impact measures and we are concerned that it is becoming or is now out of date. The Health Board indicated that it intended to develop detailed plans, but due to a lack of resources, these have not been produced.</p> <p>The Health Board faces significant performance and financial challenges and returned to special measures in February 2023. There is a need to develop clear People Strategy implementation plans which are linked to special measures work, while also ensuring effective programme arrangements and resources are in place to support its delivery (Recommendation 1).</p> |

³ The People Strategy includes a clear focus on Nurse Staffing Levels (Wales) Act 2016 and the Welsh Language (Wales) Measure 2011, but the Health Board has not appropriately considered Well-being of Future Generations (Wales) Act requirements.

⁴ The Health Board introduced East (Wrexham and Flintshire), centre (Denbighshire and Conwy), and west (Anglesey and Gwynedd) Integrated Health Communities, which are responsible for acute, community and primary care services, in August 2022 as part of a new operating model.

| What we looked at | What we found |
|---|--|
| <p>We considered whether the Health Board has a good understanding of current and future service demands. We expected to see:</p> <ul style="list-style-type: none"> • use of reliable workforce information to determine workforce need and risk in the short and longer term; and • action to improve workforce data quality and address any information gaps. | <p>We found that the Health Board has an improving understanding of current workforce capacity but needs to strengthen how it models and plans its workforce.</p> <p>The Health Board has made a concentrated effort to improve its workforce data resulting in the development of a three-year workforce profile (2022-2025). Some services, such as Child and Adolescent Mental Health Services and critical care, are starting to develop workforce plans for their service. We also understand that the Health Board has completed some Nursing workforce planning for the three Integrated Healthcare Communities and as a result it has a better understanding of discrete workforce gaps. However, the Health Board is clear that it needs to do far more to fully understand its current and future workforce requirements and set out key improvement actions in workforce plans. In particular, the Health Board needs a clearer understanding of its future service models and corresponding clinical service plans for acute and community services (Recommendation 2). Without this, it will not be able to effectively develop its workforce and associated new roles or forecast capacity and demand to ensure workforce sustainability in the medium to long term.</p> <p>The Health Board has reasonable operational workforce data such as sickness levels, vacancy, and appraisal rates which it sources from the Electronic Staff Record system (ESR). This supports day-to-day workforce analysis and management. However, there are also areas that need attention. For example, whilst there is an agreed funded establishment⁵ and establishment control process, we understand that financial data and workforce data do not always align, indicating that the approach for setting a funded establishment may need revisiting.</p> <p>The Health Board is taking steps to improve data quality, working with national working groups such as the All-Wales Data Quality Group to find shared solutions. The Health Board is also taking steps to improve service level access to workforce data by developing management dashboards. It is initially starting with the most common metrics including appraisal and statutory and mandatory training; sickness and maternity absence rates; turnover and vacancy rates. Of note, the Health Board is developing a workforce utilisation dashboard to identify the utilisation of substantive and</p> |

⁵ Establishment is the term for the workforce levels, staff roles and the NHS Agenda for Change banding for which is financially budgeted.

| What we looked at | What we found |
|--|---|
| | <p>temporary staff within rosters, measured against funded establishments in ESR. This will include staff unavailability (ie annual leave, sickness, training, and parental absence) to help provide a spotlight where staff utilisation is low. It will also include analysis of patterns of high temporary workforce authorisation requests.</p> |
| <p>We considered whether the Health Board is working with partners to help resolve current and anticipated future workforce challenges. We expected to see:</p> <ul style="list-style-type: none"> • effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and • shared solutions identified with key stakeholders to help address workforce challenges. | <p>We found that whilst the Health Board is collaborating proactively with external stakeholders to find shared solutions to workforce challenges, more needs to be done to build effective internal relationships and ownership of workforce developments.</p> <p>Internally, the central workforce team has limited capacity to engage services across the organisation. The Health Board developed the People Strategy without effective internal engagement. As a result, there seems to be little wider organisational ownership for its delivery. In addition, during our fieldwork, operational managers were trying to progress workforce planning within their service often with little or no involvement from the corporate workforce team. The Health Board has recently introduced a new ‘people team’ model which if appropriately implemented may help to bridge the gap between services and the corporate workforce team to help support new workforce developments.</p> <p>The recent external ‘assessment of key areas of workforce agenda’ highlighted concerns around leadership, behaviours and values and lack of traction of the Health Board’s ‘Stronger Together⁶’ work. The Health Board reported that it is at the initial stages of a new Culture, Leadership and Employee Engagement programme which is focussing on culture, leadership, and engagement. Given the challenges facing the organisation, there will be a need for clear reporting on progress and the impact of this work.</p> |

⁶ Stronger Together is a 3+ year system and organisational development approach to enable the Health Board to better meet its purpose and goals through the alignment of its process, behaviours, and structures. The key three phases of Stronger Together are: Discovery (Let’s Talk), Co-Design and Co-Delivery.

| What we looked at | What we found |
|-------------------|---|
| | <p>The Health Board recognises the importance of regional working to support the development of sustainable services. It actively engages its local authority partners to find shared workforce solutions through the North Wales Regional Partnership Board⁷. They are collectively seeking to strengthen integrated health and social care workforce arrangements and currently revising the North Wales Social Care and Community Health Workforce Strategy.</p> <p>The Health Board is working in partnership with Bangor University on the North Wales Medical School. It will take time before the new school helps to provide the medical capacity needed by the Health Board, but it is promising that North Wales now has improved chances for attracting medical trainees from local communities. This should give the Health Board greater potential to recruit and retain a sustainable medical workforce. It will also be important to ensure the Health Board effectively supports its students, providing good quality placements, to improve the likelihood of attracting them into permanent positions, once they graduate.</p> <p>The Health Board routinely and effectively engages with Health Education Improvement Wales (HEIW) on local workforce issues including the Talent Management programme, routine education commissioning arrangements, supporting preparation of the new North Wales medical school.</p> |

⁷ The North Wales Regional Partnership Board was established by the Social Services and Well-being (Wales) Act 2014 to ensure local health boards, local authorities and the third sector work together to deliver services, care and support that meets the needs of people who live in North Wales.

Exhibit 3: operational action to manage workforce challenges.

This section focusses on the actions the Health Board is taking to manage workforce challenges. We found that **the Health Board does not have sufficient capacity and capability to allow it to effectively support workforce planning. While its teams understand and are responding to operational key workforce challenges, the scale of the problem has meant that the level of workforce risk that the organisation is facing has not notably reduced.**

| What we looked at | What we found |
|---|--|
| <p>We considered whether the Health Board has identified sufficient resources to support workforce planning over the short, medium, and long term. We expected to see:</p> <ul style="list-style-type: none"> • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan. | <p>We found that whilst the Health Board is strengthening its People team with the introduction of People Business partners, it does not yet have sufficient resources to effectively support workforce planning or effective delivery of the People Strategy.</p> <p>The Health Board is taking some action to integrate workforce support into its new operating model structure. It has recently introduced a new People Team business partnering model which aligns an Associate Director of Workforce and a People Business Partner to each Integrated Health Community. There is also a corporate pan-organisation workforce team that support Cancer Services, Mental Health Services, and the corporate functions. Whilst these are positive developments, it will be important to ensure that within this business partnering model there is sufficient capacity and capability in respect of workforce planning. Our fieldwork indicates that currently this is not the case.</p> <p>Currently, there are vacancies in the workforce directorate, resulting in some staff working up in 'acting' positions. The gaps in senior management in the workforce directorate, alongside a significant operational caseload, are impeding the People Strategy's delivery including essential work needed on organisational development and workforce planning. There are also workforce planning capacity issues at an operational service manager level. Our focus groups identified that some service leads had started workforce planning, but, due to the corporate team's limited resources, felt they were attempting this without the necessary workforce planning expertise. Other service leads felt that operational pressures did not allow them sufficient time to 'think strategically' to develop workforce solutions.</p> |

| What we looked at | What we found |
|-------------------|---|
| | <p>As in other NHS bodies, staff costs drive much of the organisation’s expenditure. Between 2017-18 and 2022-23, the Health Board’s total annual pay costs increased by 48% to £1.04 billion. Effective workforce planning is an essential component in ensuring current and future service models are both fit for purpose and affordable. The Health Board must sufficiently invest in its corporate and devolved workforce planning capacity and capability to achieve this. This is a clear recommendation in the recent external ‘assessment of key areas of workforce agenda’ review.</p> <p>Currently, there is no workforce planning training available within the Health Board. The Health Board indicated that once all the People Business Partners are in post, they would receive an intensive training programme including workforce planning. Following this, we understand that the Health Board will roll out workforce planning training more widely, however, no timeframe has been set for this. We understand that this training will be based on HEIW’s six-step model⁸. This process will take time and needs to be effectively planned and prioritised (Recommendation 3).</p> <p>Whilst the human resources and workforce organisational development functions have a set budgetary allocation, the Health Board’s People Strategy is not costed and the Health Board has not identified the longer-term costs, skills or other resources associated with delivering it.</p> <p>The Health Board is also starting to consider the overall efficiency of its workforce as part of its annual plan development. This includes identifying possible new ways of working, elements of service redesign and reduction in variable ‘agency’ costs. This is a positive development, although the work is at too early a stage to be able to demonstrate any tangible improvements.</p> |

⁸ Health Education and Improvement Wales has developed a workforce planning toolkit based on the following six steps: 1, Define your plan, 2. Map the service change, 3. Define the workforce, 4. Workforce supply, 5. Define actions required, 6 Implement and monitor.

| What we looked at | What we found |
|--|--|
| <p>We considered whether the Health Board has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see:</p> <ul style="list-style-type: none"> • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level. | <p>We found that the Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions. However, the scale of its workforce challenges means that its mitigating actions are having minimal impact on reducing these risks.</p> <p>The Health Board has a good understanding of the range of risks which may prevent its People Strategy delivery. These relate to workforce shortages, financial pressures, and a lack of clarity about future clinical service models. Additionally, workforce shortages are limiting the Health Board's ability to meet the requirements of the Nurse Staffing Levels Act (Wales)⁹. Despite taking mitigating actions at corporate and operational levels during 2022-23, the Health Board struggled in many areas to ensure it appropriately complied with the Act¹⁰.</p> <p>Corporately, the Health Board appropriately reflects high-level short and longer-term workforce risks, which it manages through the Board Assurance Framework (BAF) and corporate risk framework. Operationally, the Risk Management Group meets regularly to review corporate risk registers and actions. The Health Board is currently seeking to consolidate a range of workforce risks to better describe the risk in the context of the risk to patient care. Nevertheless, the scale of the workforce challenges in the Health Board means that mitigating actions are having minimal effect on reducing workforce risks. Some of the arrangements to manage these risks are relatively new and will need to become further embedded to help reduce some workforce challenges. These include the review of vacancy control, a clinical workforce service review programme and monthly 'pipeline' reports for managers.</p> |

⁹ The Nurse Staffing Levels (Wales) Act 2016 was passed in March 2016. The Act places a duty on health bodies to have regard to providing appropriate nurse staffing levels. This is to ensure their nurses have the time to provide the best possible care for patients. Currently the Act only applies to adult acute medical and surgical, and paediatric inpatient wards.

¹⁰ In May 2023, the Board received the [2022-23 Nurse Staffing Levels Annual Assurance Report](#), covering the period between April 2022 and April 2023.

| What we looked at | What we found |
|---|---|
| <p>We considered whether the Health Board is effectively addressing its current workforce challenges. We expected to see:</p> <ul style="list-style-type: none"> • effective reporting and management of staff vacancies; • action to improve staff retention; • efficient recruitment practices; • commissioning of health education and training which is based on true workforce need; and • evidence that the organisation is modernising its workforce to help meet current and future needs. | <p>We found that the Health Board is working to address its operational workforce challenges through a range of recruitment, retention, and development activities. However, significant challenges remain and education commissioning is not yet supporting a sustainable workforce.</p> <p>The Health Board has the biggest workforce in NHS Wales. With a vacancy rate at 7% (Exhibit 10), it has increased its use of agency staff to help address short-term workforce gaps (Exhibit 8). The Health Board is also actively addressing operational workforce shortages by using bank staff, redeployment of existing staff and international recruitment. In addition to its routine domestic recruitment, it has supported over 100 international nurses through professional registration, resulting in their employment in the Health Board¹¹. Since October 2022, the Health Board has continued its overseas nurse recruitment programme with a plan to recruit a further 380 registered nurses over the next two years, with 58 successfully appointed to date. The Health Board is taking steps to streamline and centralise recruitment to address inefficiencies in its recruitment process. This includes managing recruitment through the resourcing managers within each IHC, which supplements the recruitment services provided by Shared Services.</p> <p>The Health Board is also experiencing challenges with staff retention (Exhibit 9). The Health Board is seeking to address this through its Joining Well/Leaving Well initiative and the work of the Strategic Recruitment and Retention Group¹². This group is responsible for developing career pathways for matrons, ward managers and head of nursing. The Health Board is also taking steps to improve its exit survey responses. However, it should also conduct regular pulse surveys/stay interviews¹³ to gauge how staff are feeling and identify any improvements it can make to help support staff retention (Recommendation 4).</p> |

¹¹ [Betsi Cadwaladr University Health Board People Strategy p.15](#)

¹² The Strategic Recruitment and Retention Group monitors and develops a forward look on recruitment and retention initiatives to mitigate nursing shortfall over the next five years.

¹³ The Health Board conducts ‘Stay interviews’ to help managers understand why employees stay and what might cause them to leave.

| What we looked at | What we found |
|-------------------|--|
| | <p>The Health Board's sickness rate (Exhibit 11) is not meeting the national target although it has started to reduce during 2023. The Welsh Government 'Assessment of key areas of workforce agenda' review recommended the need to establish a long-term organisational health and wellbeing approach with clear roles and better visibility for the Health and Well-being Leadership Group.</p> <p>The Health Board is introducing staff career progression opportunities including enhancing existing 'grow your own' and apprenticeships schemes. The Health Board's Nursing Career Framework is supporting nursing workforce development to help address workforce gaps and support succession planning needs. The Health Board is also assisting healthcare support workers' pre-registration as part of their nursing programme training.</p> <p>There are, however, weaknesses in the education commissioning process that mean that the pipeline of newly qualified staff does not meet demand. The Health Board is strengthening its educational commissioning process by aligning it with the timeline for development of its Integrated Medium Term Plan and improving how it engages services on projected needs. However, the Health Board appoints less staff than it trains through the commissioning process.</p> <p>The Health Board recognises the need to use the workforce differently and is starting to seek alternative solutions to ensure a sustainable workforce. For example, it has established its physician associates' role and physician and advanced practice roles, but the progress and scale of rollout are limited. The Health Board is also looking at opportunities to develop General Practitioners' specialties to fill secondary care gaps.</p> |

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **the Health Board’s People strategy or plan is not sufficiently supported by robust monitoring, oversight, and review.**

| What we looked at | What we found |
|---|---|
| <p>We considered whether delivery of the Health Board’s workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see:</p> <ul style="list-style-type: none"> • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations. | <p>We found that the Health Board’s approach to monitoring the impact of the People Strategy has not been strong enough and has been further compromised by the need to stand down the Partnerships, People and Population Health Committee. A revitalised approach to monitoring delivery of the Strategy is needed which should include better use of benchmarking information.</p> <p>Committee oversight on key workforce issues is not currently sufficient given the extent of the workforce challenges the organisation faces. The Health Board’s current workforce oversight is in theory split between two committees. The Performance, Finance and Information Governance Committee routinely consider operational workforce performance analysis and trends. The Partnerships, People and Population Health Committee should oversee the progress and impact of the People Strategy. However, in late February 2023, this committee was stood down following the significant changes to the Independent Member cadre on the board. As part of the re-establishment of the board and an associated review of committee arrangements, the Health Board has introduced a new People and Culture Committee, with its inaugural meeting held in January 2024.</p> <p>The last report to the Partnerships, People and Population Health Committee in January 2023 described some actions to deliver some elements of the People Strategy, but gave no sense of the overall pace of progress of strategy delivery and very little focus on the difference (the impact) it is achieving (Recommendation 5). The People and Culture Executive Delivery Group was set up to monitor the development and delivery of the People Strategy. However, the Health Board reported that changes, including the introduction of the Operating Model, have affected the continuity and effectiveness of the group’s meetings.</p> <p>Where possible, the Health Board benchmarks its workforce performance with other health bodies in Wales, comparing metrics such as turnover, sickness rates, time to hire, and recruitment checks through its workforce dashboard. As such there is an opportunity for the Health Board to benchmark</p> |

its workforce performance and identify good practice and innovation with similar organisations across the UK and internationally.

Appendix 1

Audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

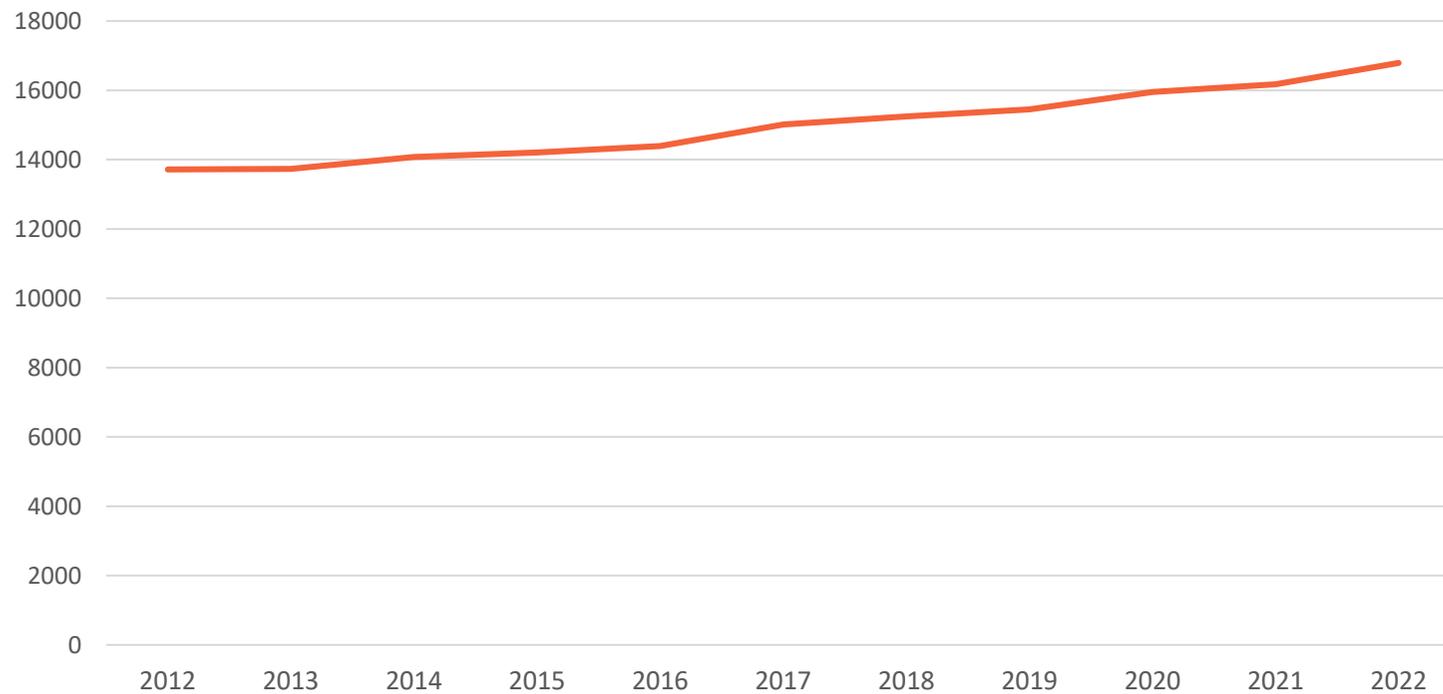
| Element of audit approach | Description |
|---------------------------|--|
| Documents | <p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none">• Workforce strategy and associated workforce plan(s)• Implementation/delivery plans for workforce strategy – high level• Evidence of evaluation of workforce strategy and/or associated initiatives• Information feeding into workforce strategy development eg needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning• Evidence of stakeholder engagement• Workforce finance and resource plans• Corporate and operational risk registers• Document showing recruitment process, recruitment, and retention initiatives• Corporate and operational level oversight and monitoring of workforce metric and strategy delivery |
| Interviews | <p>We interviewed the following:</p> <ul style="list-style-type: none">• Deputy Executive Director of People• IHC Medical Director x 3• IHC Director x2• Head of Financial Reporting |

| Element of audit approach | Description |
|---------------------------|---|
| | <ul style="list-style-type: none"> • Head of Financial Planning • Information Officer • Assistant Director of Nursing • Assistant Director for Strategy • Associate Director of People • Associate Director Workforce • Workforce Information Leads • Deputy Executive Medical Director |
| Focus groups | <p>We ran two focus groups with:</p> <ul style="list-style-type: none"> • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services. |

Appendix 2

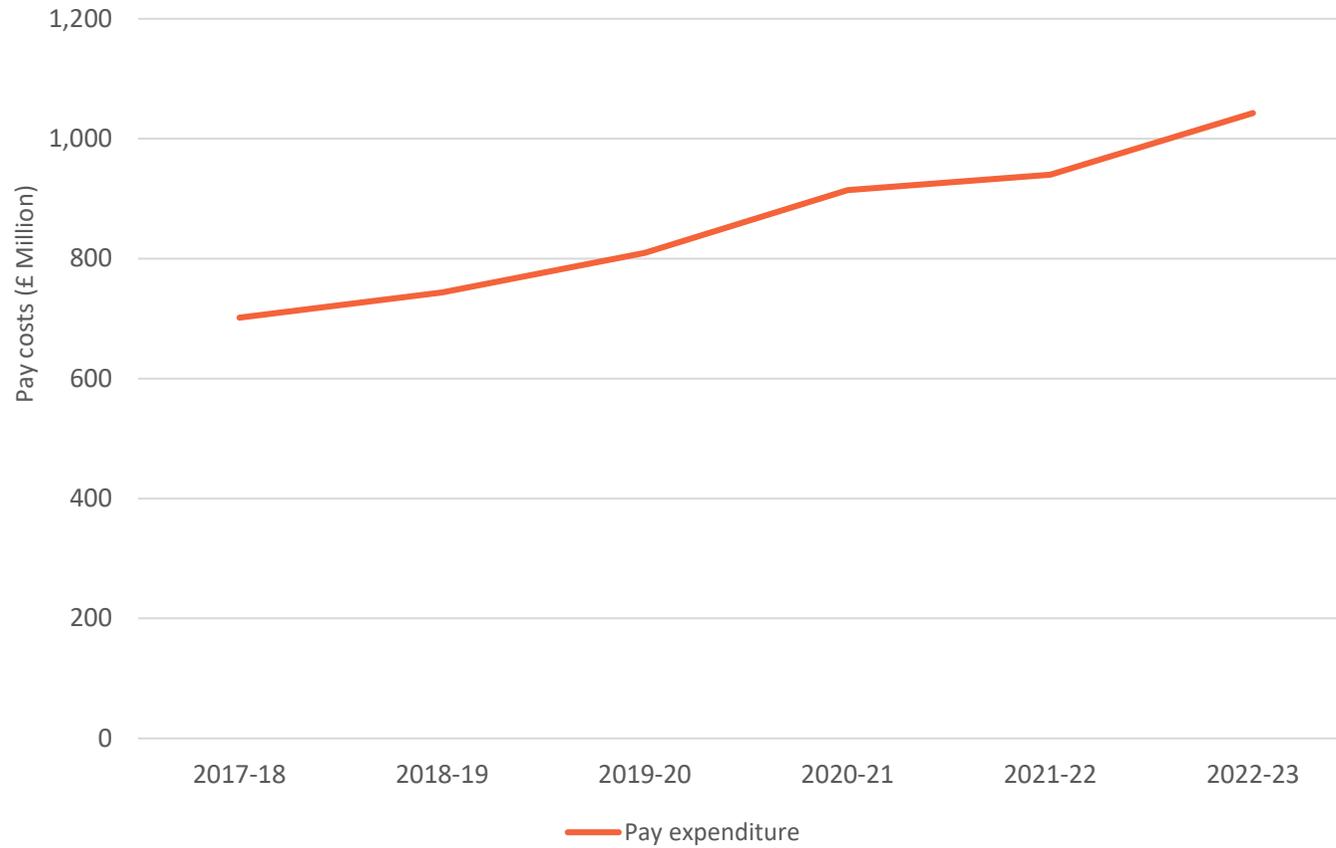
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full-time equivalent), Betsi Cadwaladr University Health Board



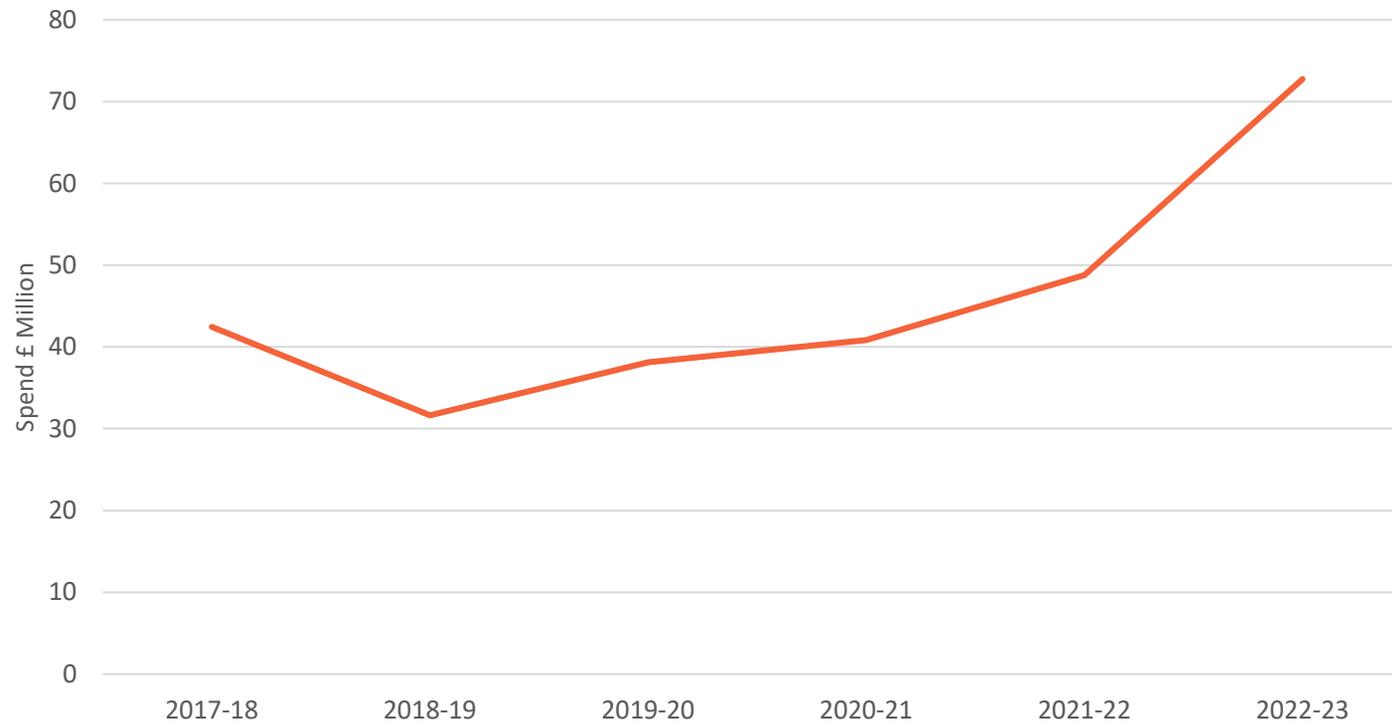
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual workforce costs, Betsi Cadwaladr University Health Board



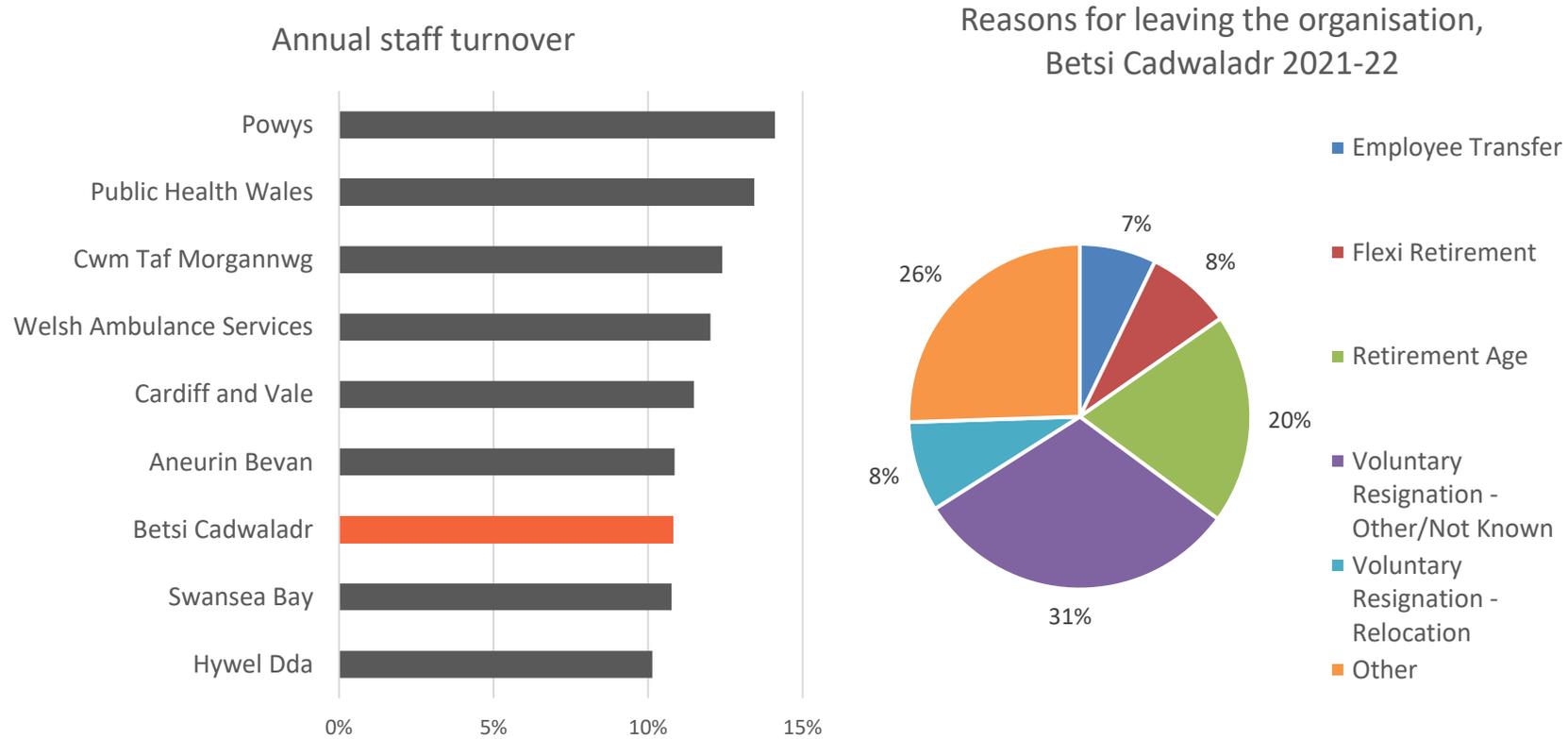
Source: Monthly Monitoring Returns reported to the Welsh Government

Exhibit 8: trend of expenditure on workforce agency £ million, Betsi Cadwaladr University Health Board



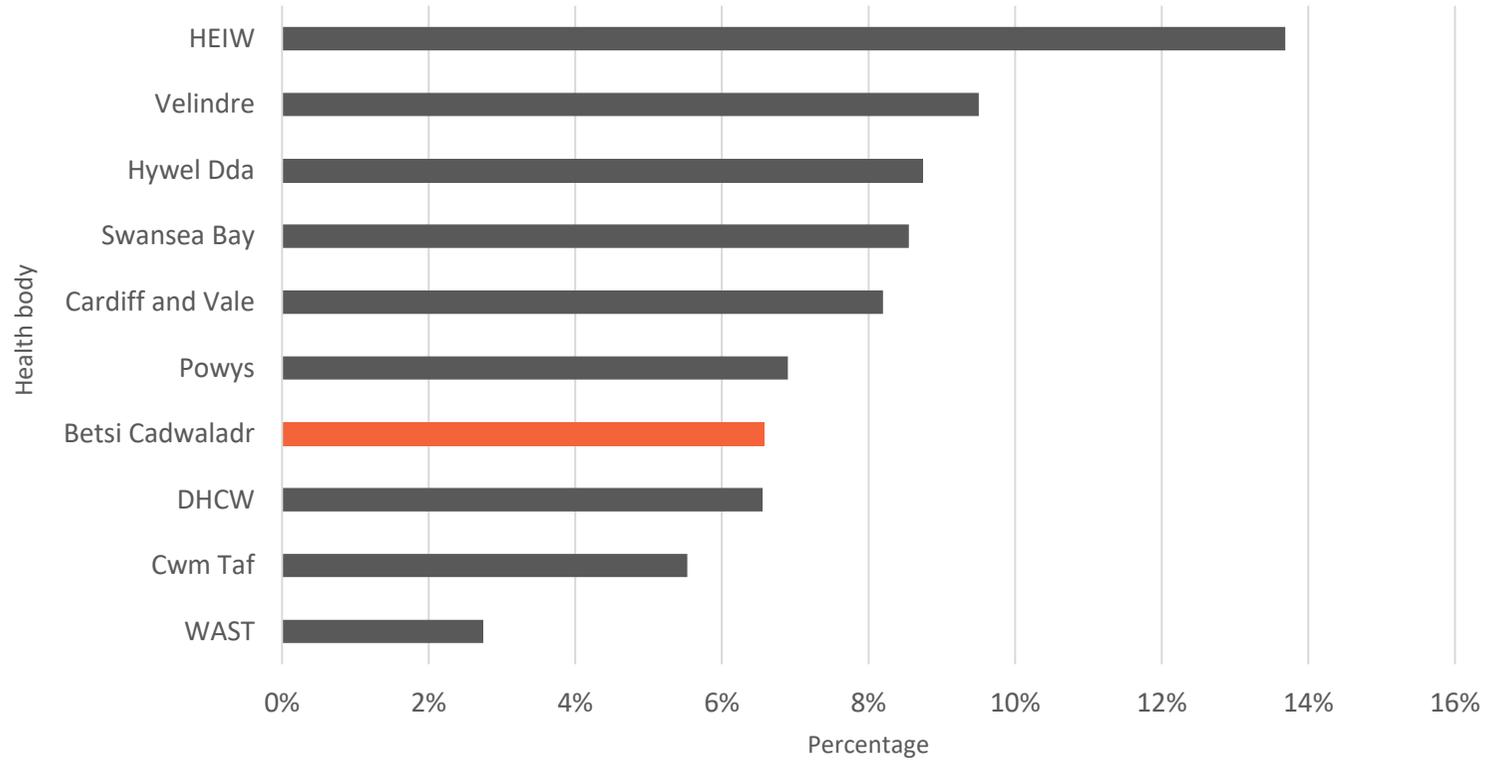
Source: Monthly Monitoring Returns reported to the Welsh Government

Exhibit 9: annual staff turnover and reason for leaving, 2021-22, Betsi Cadwaladr University Health Board



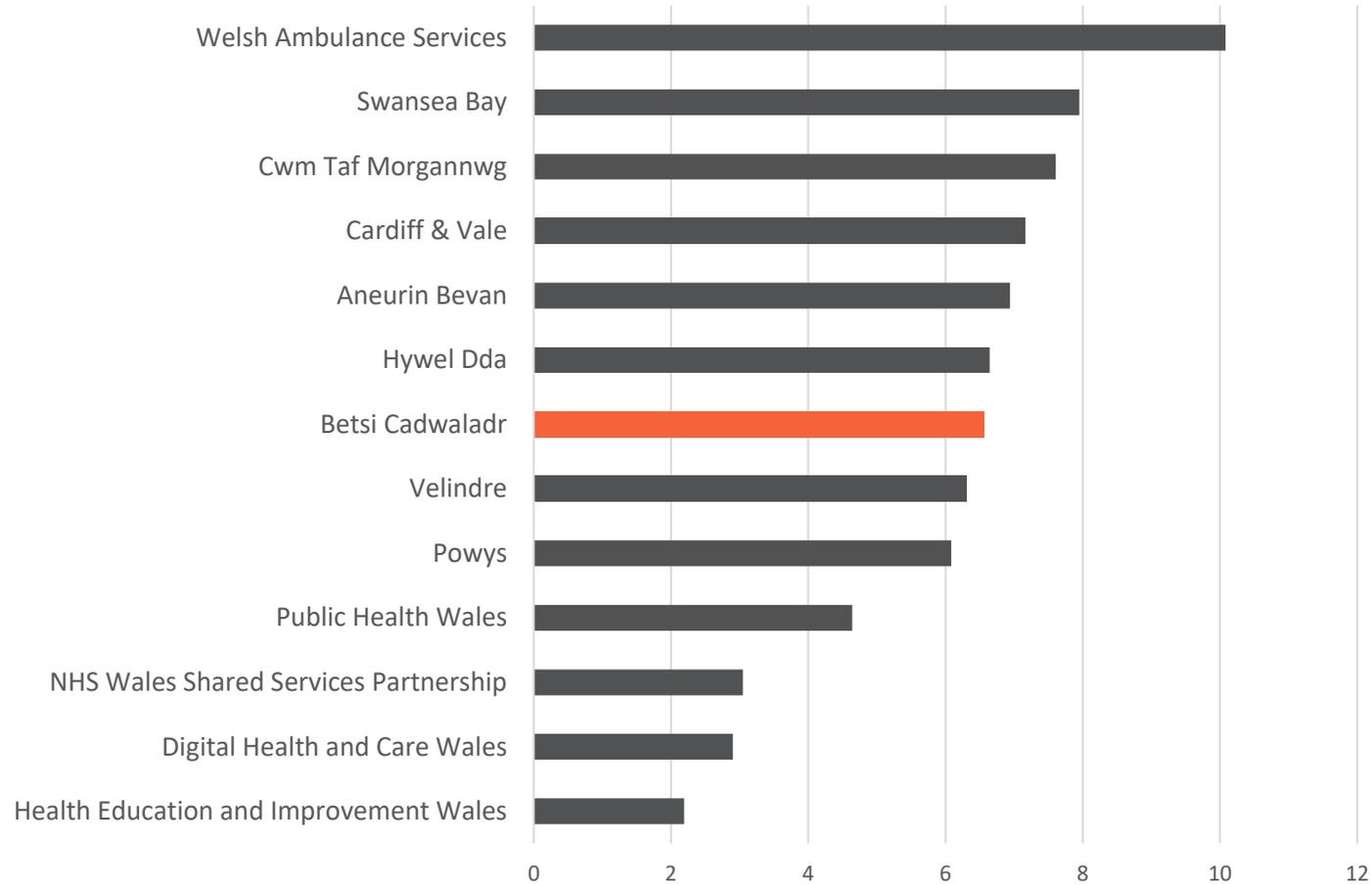
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancies as a percentage of total establishment, as of March 2022



Source: health body data request

Exhibit 11: sickness absence by organisation, 2022



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Betsi Cadwaladr University Health Board's response to audit recommendations.

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|---|--|---|
| R1 | <p>Delivery of the People Strategy</p> <p>The Health Board should strengthen and further develop their current implementation plan for delivery of the People Strategy that:</p> <p>a) Sets out clear goals and targets and prioritised activities, with clear delivery timelines and accountabilities. (High priority)</p> <p>b) Incorporates actions to deliver the 30 recommendations made in the Assessment of key areas of workforce agenda. (High priority)</p> | <p>a) The Health Board has set out clear goals, targets and prioritised activities as part of its special measures programme in 2023-24 and has built them into the annual plan for 2024-25. Clear delivery timelines and accountabilities will be set out as part of the delivery of the annual plan.</p> <p>b) The identified recommendations will be reviewed in light of the work already carried out under Special Measures and will be developed into actions as part of the ongoing work with the Annual Plan and as part of the delivery work overseen by the Organisation Development Steering Group chaired by the CEO and reporting into the newly established People and Culture Committee.</p> | <p>End of July 2024</p> <p>End of September 2024</p> | <p>Deputy Director of People</p> <p>Deputy Director of People</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|---|--|--|---|
| R2 | <p>Service level workforce planning</p> <p>In order to better understand its current and future workforce requirements the Health Board should:</p> <p>a) Undertake analysis to understand its current workforce requirement and future service models to determine the workforce needed to create sustainable and efficient acute and community services. This will require:</p> <ul style="list-style-type: none"> – forecasting of service demand – service modelling; and – analysis of capacity requirements, by specialism and profession. (High priority) <p>b) Ensure there is sufficient capacity and capability within the Health Board to support effective workforce planning; this should include identifying where scope exists to re-deploy existing staff resources and ensure there are clearer remits within existing job specifications. (High priority)</p> | <p>a) There is a baseline position now in place as a result of the work done on the workforce dashboards and development of local plans as part of the annual plan development; further analysis will be carried out through 2024 to ascertain demand and capacity requirements across services by specialism and profession.</p> <p>b) This work will be picked up as part of the ongoing embedding of the new people services structure with dedicated resource identified to support specialised workforce planning and further development via a specified training programme of the People Service Business Partners and identified planning leads across the organisation. Job Descriptions across these key roles will be made clearer in the relevant job specifications associated with the identified roles.</p> | <p>End of December 2024</p> <p>End December 2024</p> | <p>Associate Director of Workforce Optimisation</p> <p>Associate Director of Workforce Optimisation</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|---|--|---|
| R3 | <p>Support and training</p> <p>The Health Board should develop an evaluation framework to measure the success of the workforce planning training programme it intends to roll out. The evaluation of the training programme should incorporate an early assessment of whether the training is achieving it's intended aims. (Medium priority)</p> | <p>This action will be built into the training programme outlined in R2b.</p> | <p>End of December 2024</p> | <p>Associate Director of Workforce Optimisation</p> |
| R4 | <p>Exit and pulse surveys</p> <p>To better understand issues affecting staff turnover the Health Board should:</p> <p>a) Develop an approach to increase exit survey response rates and ensure feedback from the surveys informs retention activities. (Medium priority)</p> <p>b) Conduct regular pulse surveys/stay interviews to gauge how staff are feeling and identify any improvements it can make to support retention and manage staff turnover. (Medium priority)</p> | <p>a) This work will be incorporated into the wider retention work plan being developed by the organisation and will be rolled out across 2024-25.</p> <p>b) This work will be incorporated into the wider retention work plan being developed by the organisation and will be rolled out across 2024-25.</p> | <p>End of December 2024</p> <p>End of March 2025</p> | <p>Deputy Director of People</p> <p>Deputy Director of People</p> |

| Ref | Recommendation | Organisational response | Completion date | Responsible officer |
|-----|--|--|------------------------------|----------------------------------|
| R5 | <p>Monitoring and oversight</p> <p>The Health Board should strengthen its approach to monitoring delivery of the People Strategy and associated implementation plans and workforce programmes. The monitoring approach should have a focus on whether the Strategy is achieving its desired aims and outcome, include engagement with the new People and Culture Committee and incorporate implementation of the recommendations from the external ‘assessment of key areas of workforce agenda review.’ (Medium priority)</p> | <p>The monitoring of the delivery of the Health Board’s workforce priorities will be overseen through the revised governance structures now in place. These will outlined as part of this management response and the new People Report being developed for the People and Culture Committee will incorporate this monitoring.</p> | <p>End of September 2024</p> | <p>Deputy Director of People</p> |



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Betsi Cadwaladr University Health Board – Detailed Audit Plan 2024

Audit year: 2024 – Audit of the 2023-24 accounts

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Inspire



and empower
the Welsh
public sector to
improve



Fully exploit
our unique
perspective,
expertise and
depth of insight



Strengthen our
position as an
authoritative,
trusted and
independent
voice



Increase our
visibility,
influence and
relevance



Be a model
organisation for
the public sector
in Wales and
beyond

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Introduction

I have now largely completed my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2024.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.



Adrian Crompton

Auditor General for
Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our [Statement of Responsibilities](#).

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

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

Performance audit work

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

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

My performance audit work is designed to comply with auditing standards set out by the International Organisation of Supreme Audit Institutions (INTOSAI). This is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Your audit at a glance



My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant financial statement risk

- Management Override
- Fraud in revenue recognition
- Fraud in expenditure recognition
- Failure to achieve break-even

Other areas of audit focus

- Decommission of the Losses and Special Payments Register (LaSPaR)
- Remuneration disclosures
- Quality of draft financial statements



My performance audit will include:

- Structured Assessment – core,¹
- Structured Assessment – deep dive review of investment in digital systems to support service resilience and transformation
- All-Wales Thematic Review – managing demand for urgent and emergency care
- Local work:
 - Use of the £297 million strategic financial assistance provided by the Welsh Government for the 3.5 year period October 2021 to March 2024
 - Follow on review of quality governance arrangements

¹ The 2024 Structured Assessment will include a review the Health Board's arrangements for setting its Wellbeing of Future Generations objectives



Materiality

| | |
|---------------------|-----------|
| Materiality | £21.467 m |
| Reporting threshold | £1.073 m |

Financial statements' materiality



Materiality £21.467 million

My aim is to identify and correct material misstatements, that is, those that might otherwise cause the user of the accounts to be misled.

Materiality is calculated using:

- 2023-24 gross expenditure of £2,146 million (estimated using 2022-23 actual expenditure)
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).



Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

- Remuneration report: £5,000 banding
- Related party disclosures £1,000

Significant financial statements' risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

| Significant risk | Our planned response |
|---|--|
| <p>The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].</p> | <p>The audit team will:</p> <ul style="list-style-type: none"> • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business. |
| <p>There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.27].</p> <p>We have noted below the financial pressures faced by the Health Board and there is a risk that cut off will not be correctly applied to funding received around the year end.</p> | <p>The audit team will:</p> <ul style="list-style-type: none"> • agree funding received around the year end has been included within the correct year; • confirm Welsh Government funds not utilised in year have been treated correctly; and • consider the completeness of miscellaneous income. |
| <p>There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10].</p> <p>We have noted below the financial pressures faced by the Health Board and</p> | <p>The audit team will:</p> <ul style="list-style-type: none"> • substantively test all material areas of pay and non-pay expenditure; |

| Significant risk | Our planned response |
|--|--|
| <p>there is a risk that cut off will not be correctly applied to expenditure incurred around the year end.</p> | <ul style="list-style-type: none"> • review the basis of accruals for any estimation bias; • review the year-end cut-off of expenditure; • review the basis of new provisions and changes in provision levels in year; and • review the amendments made to brought forward balances to ensure valid. |
| <p>The Health Board is under significant pressure to achieve the year end position agreed with Welsh Government of a £20 million deficit.</p> <p>The reported February 2024 actual position was a £9.7 million deficit with a forecast year end deficit of £33.0 million. Despite this forecast, the Health Board is confident that it will achieve a year end deficit of £27 million following confirmation of additional Welsh Government funding of £5.7m for Continuing Health Care (CHC).</p> <p>The current financial pressures increase the risk that management judgements and estimates could be biased to achieve the agreed year end out turn and the financial duty.</p> <p>The Health Board met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23. If the Health Board fails to meet this financial duty in 2023-24, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.</p> | <p>The audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias</p> |

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

| Audit risk | Our planned response |
|---|---|
| <p>From 1 December 2023, the Losses and Special Payments Register (LaSPaR) which is used to calculate the losses and many of the provisions balances in the accounts has been de-commissioned.</p> <p>For the remainder of 2023-24, a model excel spreadsheet will be used to record losses, special payments and to calculate year-end balances.</p> <p>There is a risk that the transactions and balances related to losses and special payments are materially misstated due to:</p> <ul style="list-style-type: none"> • the data transfer between the LaSPaR system and the excel model not being complete and accurate; and • the excel model miscalculating balances, due to spreadsheet/modelling errors and/or incorrect data entry. | <p>The audit team will:</p> <ul style="list-style-type: none"> • test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets; • consider the design and implementation of controls (if any) in place to mitigate error; • review the year-end spreadsheet to ensure that there are no significant errors or issues in the compilation of figures for the accounts; and • review transactions back to supporting evidence (e.g. Quantum reports) on a sample basis. |
| <p>The Remuneration Report contains important disclosures required by Welsh Government and accounting standards.</p> <p>The 2022-23 Remuneration Report was submitted for audit after the Health Board requested an extended deadline that was agreed with Welsh Government. It also required a significant number of</p> | <p>The audit team will review the disclosures to ensure they are in line with our understanding of the changes that have occurred during the year and that they are complete and accurate.</p> |

amendments to ensure the information reported was factually accurate

There have been significant changes to the composition of Senior Management and Independent Members during the year which will need to be accurately reflected within the Remuneration report.

The draft financial statements submitted for audit in 2022-23 were not of the quality we expected.

The working papers received to support key disclosures in the financial statements (for example Property Plant and Equipment and Right of Use Assets) were poor and lacked a clear audit trail.

Our audit work identified significant issues and errors which led to amendments to the accounts or the need for additional audit work.

This impacted on the timely delivery of our audit and the submission of the audited financial statement to Welsh Government.

The deadline set by Welsh Government for the submission of the 2023-24 audited financial statements has been brought forward to 15 July 2024. If improvements are not made there is a risk that the deadline for submission will again not be met.

The audit team have been working with the Health Board's finance team to understand the arrangements and processes established to improve the quality of the draft financial statements.

The audit team will monitor the closedown plan and review the draft financial statements and working papers following receipt on 3 May 2024 to identify whether there are any issues that could impact on the audit timetable.

Financial statements' audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

| Planned output | Work undertaken | Report finalised |
|--|--------------------|------------------|
| 2024 Detailed Audit Plan | March – April 2024 | April 2024 |
| Audit of financial statements work: | | |
| <ul style="list-style-type: none">Audit of Financial Statements Report | May – July 2024 | July 2024 |
| <ul style="list-style-type: none">Opinion on the Financial Statements | May – July 2024 | July 2024 |

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

| Area of work | Scope of the work | Planned timescales |
|--|---|--|
| <p>Structured Assessment - core</p> | <p>Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.</p> <p>My core 2024 structured assessment work will review the following areas:</p> <ul style="list-style-type: none"> • Board and committee cohesion and effectiveness. • Corporate systems of assurance. • Corporate planning arrangements; and • Corporate financial planning and management arrangements. <p>My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.</p> | <p>Fieldwork to commence between June and August 2024 with reporting by the end of October 2024.</p> |
| <p>Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation</p> | <p>In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. This work was deferred from</p> | <p>Fieldwork to commence during the autumn of 2024 and reporting by the end of March 2025.</p> |

| Area of work | Scope of the work | Planned timescales |
|--|--|--|
| | <p>2023, following my decision to replace the work with a review of the Health Board's approach to financial efficiencies.</p> | |
| <p>All Wales thematic review of urgent and emergency care – managing demand for urgent and emergency care</p> | <p>In my 2020 audit plan for the Health Board, I set out my intention to undertake work to examine arrangements to manage demand for urgent and emergency care services, as part of my wider work focused on these services.</p> <p>Due to the COVID-19 pandemic, I deferred this work to allow NHS bodies to respond to the pandemic, with a plan to bring the work back online once the impact of the pandemic had subsided and my work on patient flow out of hospital was completed. I am now able to take forward my work on managing demand for urgent and emergency care. The work will be undertaken during 2024 and will be funded from this year's audit fee.</p> <p>Consequently, I have decided to refund the Health Board the fee paid for this work as part of my 2020 audit plan.</p> <p>My 2024 urgent and emergency care work will focus on:</p> <ul style="list-style-type: none"> • The robustness of plans to manage the demand on urgent and emergency care services; • The effectiveness of arrangements to encourage and enable people to access the right care, in the right place, at the first time; and • The effectiveness of arrangements to monitor the performance of urgent and emergency care services and apply lessons learnt to improve the services further. | <p>Fieldwork commenced in April 2024 and reporting by the end of September 2024.</p> |

| Area of work | Scope of the work | Planned timescales |
|---|---|--|
| <p>Local project work – Use of the strategic financial assistance provided by the Welsh Government for the 3.5-year period October 2020 to March 2024.</p> | <p>My work will encompass a high-level examination of the Health Board’s use of the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020. The exact focus of this work will be determined following provisional information requests made as part of the audit planning process. However it is likely to include an assessment of the extent to which the Health Board can demonstrate how the funding has been aligned to the previous targeted intervention areas, and the extent to which use and impact of the additional funding was monitored by the Health Board.</p> | <p>Provisional audit planning information request will be made in May 2024. Any additional fieldwork to commence following this.</p> |
| <p>Local project work - Follow on review of quality governance arrangements.</p> | <p>My work on quality governance will examine progress in addressing issues identified in my previous audit work. The scope of the work will be determined during the audit planning process, but it is likely to include the review of:</p> <ul style="list-style-type: none"> • quality strategy and plans; • the Health Board’s arrangements to implement the Duties of Quality and Candour; • quality management arrangements in specific areas such as incidents, concerns and harms; • organisation responses to independent reviews, inspections, and inquiries; • use of staff concerns and whistleblowing to inform quality improvement; and • quality governance and oversight at senior management and committee levels. <p>I intend to examine quality governance arrangements within Urology and Mental Health Services to help comment on the</p> | <p>The exact timing of the work will be discussed with the Health Board.</p> |

| Area of work | Scope of the work | Planned timescales |
|--------------|--|--------------------|
| | operational effectiveness of the above arrangements. | |

In January 2024 we published our [Fee Scheme](#) for the 2024-25 year as approved by the Senedd Finance Committee. My fee rates for 2024-25 have increased by an average of 6.4% as a result of unavoidable inflationary pressures and the ongoing need to invest in audit quality.

I estimate your total audit fee will be £513,256.

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

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

| Audit area | Proposed fee for 2024 (£) ² | Actual fee for 2023 (£) |
|---|--|----------------------------|
| Audit of Financial Statements | 300,221 | 405,163³ |
| Performance audit work: | | |
| • Structured Assessment (including deep dive on digital transformation) | 98,164 | 89,246 |
| • All-Wales thematic review | 42,627 | 48,135 |
| • Local projects | 72,243 | 62,840 |
| Performance work total | 213,035 | 200,221 |
| Total fee | 513,256 | 605,384 |

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

³ The original planned financial audit fee for the audit of the 2022-23 accounts was £282,163. The actual final fee for that work was £405,163. The £123,000 increase is a result of additional costs incurred due to issues identified within the 2022-23 accounts and the qualification matters reported as part of the audit of accounts.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

| Name | Role | Contact details |
|------------------|--|--|
| Dave Thomas | Audit Director (Performance Audit) & Engagement Director | dave.thomas@audit.wales |
| Matthew Edwards | Audit Director (Financial Audit) | matthew.edwards@audit.wales |
| Michelle Phoenix | Audit Manager (Financial Audit) | michelle.phoenix@audit.wales |
| Andrew Doughton | Audit Manager (Performance Audit) | andrew.doughton@audit.wales |
| Simon Monkhouse | Audit Lead (Financial Audit) | simon.monkhouse@audit.wales |
| Natalie Cole | Audit Lead (Financial Audit) | natalie.cole@audit.wales |
| Fflur Jones | Audit Lead (Performance Audit) | fflur.jones@audit.wales |

I can confirm that the core members of my audit team are independent of the Health Board. Some junior members of our financial audit team do have close relations who work in the Health Board and we have put the necessary procedures in place for these staff to safeguard our independence and objectivity.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2023](#).

Our People



The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality



The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance



The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

| | |
|---|--|
|  | our <u>Good Practice</u> work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire. |
|  | our <u>newsletter</u> which provides you with regular updates on our public service audit work, good practice, and events. |
|  | our <u>publications</u> which cover our audit work completed at public bodies. |
|  | information on our <u>forward performance audit work programme 2023-2026</u> which is shaped by stakeholder engagement activity and our picture of public services analysis. |
|  | various <u>data tools</u> and <u>infographics</u> to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery. |

You can find out more about Audit Wales in our [Annual Plan 2024-25](#) and [Our Strategy 2022-27](#).



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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.