

Bundle BCU Audit, Risk and Assurance Committee 20 October 2026

1.0 09:30 - PRELIMINARY MATTERS

1.1 AC26.98 Welcome and apologies

1.2 AC26.99 Declarations of interest

1.3 AC26.100 To approve the minutes of the previous meeting held on 18.8.26
AC26.100 Minutes Audit Committee 18.8.26 v0.1 unconfirmed PUBLIC

1.4 AC26.101 Summary action log
AC26.101 Summary Action Log public ARAC

2 GOVERNANCE, RISK AND ASSURANCE

2.1 09:35 - AC26.102 Update on Outstanding Audit Recommendations - Acting Director Digital, Data and Technology

AC26.102 Open Audit Recs and CRR BAF Risks DDaT V3

2.2 09:50 - AC26.103 Corporate Governance Report

AC26.103a Corporate Governance report October 2026 v1.0

AC26.103b Appendix Corporate Governance Improvement Plan

2.3 10:00 - AC26.104 Integrated Compliance Report

AC26.104a Compliance report 20.10.2026 v1.00

AC26.104b App 1 - Summary of recs for closure v2.00

AC26.104c App 2 - IA Unsatisfactory and High v1.00

AC26.104d App 3 - IA Limited open and high v1.00

AC26.104e App 4 - AW Open v1.00

AC26.104f App 5 - ID24898 -PSOW final PI report Bilingual

2.4 10:10 - AC26.105 Standards of Business Conduct

AC26.105 Standards of Business Conduct final

2.5 10:20 - AC26.106 Decision Making and Prioritisation Framework

AC26.106a Decision Making and Prioritisation Framework v3

AC26.106b Decision Making Framework Version 6.7 9 Oct 2026 PPJ

AC26.106c Draft Final Op Governance Arrangements Version 9 Oct - PPJ

2.6 10:35 - AC26.107 Risk Management Framework

AC26.107a RM01 Risk Management Framework Review - V1.0

AC26.107b Appendix 1 RM Framework RM01

3 FINANCE

3.1 10:50 - AC26.108 Post Payment Verification report

AC26.108a PPV report

AC26.108b PPV Paper October 2026

3.2 11:00 - AC26.109 Procurement Annual Report

AC26.109a -NWSSP Procurement AR Oct 26

AC26.109b BCU Annual Assurance Report 2526 V2 Final

- 4 11:10 - Comfort break
- 5 11:20 - INTERNAL AUDIT
 - 5.1 AC26.110 Internal Audit Progress Report
 - AC26.110a BCUHB IA Progress report October 2026
 - AC26.110b BCUHB ARAC IA progress report October 2026
- 6 11:40 - EXTERNAL AUDIT
 - 6.1 AC26.111 External Audit Progress Report
 - AC26.111 BCUHB Audit Wales update report (October 2026) (1)
 - 6.2 AC26.112 Audit Wales reports
 - AC26.112a Audit Wales Betsi Cadwaladr cancer services - report (FT)
 - AC26.112b Audit Wales BCUHB Cancer Review MRF
 - AC26.112c Audit Wales BCUHB NHS Estates - Final (Not including management response)
 - AC26.112d Betsi Cadwaladr UHB NHS Estates MRF - v0.3 Final
- 7.0 COUNTER FRAUD
 - 7.1 11:55 - AC26.113 Local Counter Fraud Service Progress Report
 - AC26.113a PUBLIC - Q2 26-27 Counter Fraud Report
 - AC26.113b Public CFraud appendix A Dashboard
- 8.0 Additional items
 - 8.1 12:00 - AC26.114 Learning Repository
 - AC26.114a Audit Committee BCUHB Learning Repository
 - AC26.114b bcu-learn-oct-update
 - 8.2 12:15 - AC26.115 Well Led Review progress update (verbal)
- 9 12:25 - CLOSING BUSINESS
 - 9.1 AC26.117 Agree Items for Referral to Board / Other Committees
 - 9.2 AC26.118 Review of meeting effectiveness
 - 9.3 AC26.119 Date of the next meeting :
- 10 12:30 - Resolution to exclude the Press and Public

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed minutes of the Audit Committee
held on 18 August 2026
in the Boardroom, Carlton Court, St Asaph and via Teams

Name	Title
Committee Members Present	
Paul Lambert	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member
Dyfed Jones	Independent Member (via Teams)
Rhian Watcyn Jones	Independent Member (via Teams)
In Attendance	
Russell Caldicott	Executive Director of Finance
Simon Cookson	Director Audit and Assurance, NHS Wales Shared Services Partnerships (NWSSP)
Glesni Driver	Head of Statutory Compliance & Inquiries
Dyfed Edwards	Health Board Chair (via Teams – part meeting)
Debbie Eyitayo	Executive Director People Services and Organisational Development (via Teams – part meeting)
Dave Harries	Head of Internal Audit, NWSSP
Fflur Jones	Performance Audit Lead, Audit Wales
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Stuart Keen	Director of Environment and Estates (via Teams – part meeting)
Martyn Lewis	Auditor, NWSSP (via Teams – part meeting)
Michelle Phoenix	Financial Audit Manager, Audit Wales
Denise Roberts	Head of Capital, Compliance and Business Intelligence - Finance (via Teams – part meeting)
Carol Shillabeer	Chief Executive (part meeting)
Paul Stocker	Audit Manager, NWSSP (part meeting)
Danielle Timmins	Head of Local Counter Fraud
Pam Wenger	Director Corporate Governance
Observers	
Dr Pamela Johnston	Well Led Review Advisor (part meeting)
Peter Milne	Member of the Public (by invitation via Teams)
David Graves	Member of the Public (part meeting via Teams)
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Diane Davies	Corporate Governance Manager (via Teams)

PRELIMINARY MATTERS

AC26.72 Welcome and apologies

The Committee noted that Dr Pamela Johnston was attending as an observer in her role as Well Led Review Advisor for the first hour of the meeting. The Committee also noted members of the public observing remotely.



Apologies were received from Huw Richards, Internal Audit and Teresa Owen, Deputy Chief Executive and Executive Director of Allied Health Professionals and Health Sciences.

The Chair reminded attendees that the Committee continued to play a critical role in strengthening governance, assurance and accountability across the organisation, particularly as it evolved towards a broader Audit, Risk and Assurance Committee function.

The Committee noted the attendance and apologies.

AC26.73 Declarations of Interest

The Committee Chair advised that in respect of item AC26.88, he had been a member of Bangor University Council from 2016 until July 2026 however, he had stood down fully from all responsibilities. Until December 2026, he would remain Pro Vice-Chancellor but not as a Council Member. Additionally, for the latter period whilst he was Council Member, he was Chair of the University's Audit, Risk and Assurance Committee (ARAC). He advised that the subject of item AC26.88 was a substantive item considered by ARAC after he had been appointed as an Independent Member of BCUHB, he had therefore recused himself and the Deputy Chair of Bangor University ARAC chaired that particular item.

AC26.74 To approve the unconfirmed minutes of the previous meetings held on 21.4.26 and 23.6.26

The minutes of the meetings held on 21 April 2026 and 23 June 2026 were approved as a true and accurate record. It was noted that whilst the committee was supportive of using 'co-pilot' to support the recording of accurate minutes, it was important that it was used as a tool to support the team and that more attention to be paid to the drafting.

It was resolved that the Committee

- **APPROVED** the unconfirmed minutes of the meetings held in public on 21.4.26 and 23.6.26.

AC26.75 Summary action log

Members received the action log and agreed to close the actions as detailed. In considering the action log, it was agreed to include an additional action as detailed below:

- *Provide assurance regarding 21.4.26 meeting item : Internal Audit plan 2026-2027, bullet point 3 on page 6 regarding zero-based budgeting readiness and the shift towards primary and community care & partnership working, which had been identified within the 21.4.26 minutes.*

It was resolved that the Committee

- **AGREED** updates provided to the summary action log

GOVERNANCE, RISK AND ASSURANCE

AC26.76 Update on Outstanding Audit Recommendations - Director of Corporate Governance

The Committee received the report and noted progress in addressing outstanding Internal Audit and Structured Assessment recommendations. In doing so, the Committee:

- Noted that substantial work had been undertaken over the previous twelve months to strengthen governance arrangements and address historical recommendations.
- Noted that the Learning and Regulatory Reporting audit had identified weaknesses in organisational learning arrangements, which had informed the establishment of a Governance Regulatory Group jointly chaired by the Director of Corporate Governance and the Executive Medical Director.
- Noted that the improvements implemented through this programme had strengthened organisational learning processes and contributed to the de-escalation of the associated corporate risk.
- Noted ongoing progress in implementing the Executive Committee Governance recommendations.
- Noted that completion of a number of actions remained dependent on wider work relating to the Scheme of Reservation and Delegation and the future Executive Committee operating arrangements.

In discussing the report, the Committee:

- Noted that whilst improvements had been made in relation to Standards of Business Conduct compared to previous years, significant challenges remained, particularly regarding compliance with Declarations of Interest requirements and the recording of Gifts and Hospitality.
- Sought assurance regarding how the effectiveness of completed audit recommendations was assessed. The Committee was advised that closure evidence was reviewed and validated before recommendations were formally closed, with Limited and Unsatisfactory Assurance recommendations remaining subject to follow-up audit activity and future effectiveness testing.
- Highlighted the need for a risk-based approach to monitoring Declarations of Interest compliance, particularly amongst individuals with delegated authority for financial decision-making, and noted that greater visibility of compliance levels within these higher-risk groups would strengthen assurance.
- Acknowledged the significant volume of historical audit recommendations inherited by the organisation and the challenge of securing sustainable improvement whilst continuing to respond to new recommendations.
- Noted the key risks associated with incomplete declarations of interest, weaknesses in Gifts and Hospitality controls, and the potential for control failures where recommendations were not fully embedded.
- Received assurance that recommendations continued to be actively monitored, that closure evidence was subject to scrutiny and validation, that Internal Audit follow-up arrangements remained in place, and that Executive accountability for implementing recommendations was continuing to strengthen.

The following action was agreed:

- **AC26.76.01** Director of Corporate Governance to provide a report to the October meeting regarding compliance with Declarations of Interest requirements, including compliance within staff groups holding delegated financial authority.

It was resolved that the Committee

- **NOTED** the report, received assurance regarding the arrangements for validating and monitoring the implementation of audit recommendations, and requested further assurance on compliance with Declarations of Interest and Gifts and Hospitality requirements within higher-risk staff groups.

AC26.77 Corporate Risk Register Report

The Committee received the Corporate Risk Register report and noted the position previously considered by the Board in July 2026.

In discussing the report, the Committee:

- Noted the refreshed reporting format, which had been developed to improve transparency regarding risk ownership, assurance arrangements and risk oversight, together with the work undertaken to strengthen consistency in risk management processes across the organisation.
- Noted that a number of corporate risks remained above Board-approved risk appetite levels and that these continued to be subject to regular scrutiny through Executive Committee, Board Committees and supporting governance structures.
- Received assurance regarding the operation of the escalation process set out within the Risk Management Framework, including the role of the Risk Scrutiny Group.
- Reflected that, whilst arrangements for the identification, assessment and reporting of risks had matured, greater emphasis was now required on delivering measurable risk reduction.
- Noted concern that several risk profiles had remained static for a prolonged period and agreed that risks operating above Board appetite should be supported by clear improvement programmes, delivery plans and measurable milestones demonstrating progress towards risk reduction.
- Discussed the need for future reporting to provide greater assurance regarding the effectiveness and impact of actions implemented following escalation decisions.
- Noted that the Committee Chair and the Director of Corporate Governance were considering how best to support Executive Leads in reducing risks assessed as being above Board appetite.

The Committee recognised the risks associated with corporate risks remaining above appetite without a clear reduction trajectory, limited visibility of the effectiveness of escalation arrangements, an overreliance on risk monitoring rather than mitigation, and potential disconnects between operational and corporate risk management.

The following action was agreed:

- **AC26.77.01** Director of Corporate Governance to bring forward proposals to strengthen oversight and reporting of risks above Board appetite, aligned to IMTP delivery.

It was resolved that the Committee

- **NOTED** the report and the ongoing oversight of risks operating above Board-approved risk appetite.

- **RECEIVED ASSURANCE** that governance arrangements and recent improvements to the Corporate Risk Register framework supported effective corporate risk management and reporting.

AC26.78 Board Assurance Framework 2026/27

The Committee received the report:

- Pam Wenger presented the refreshed Board Assurance Framework and outlined the work undertaken to align it with the Board's revised Strategic Objectives and approved Integrated Medium-Term Plan.

In discussing the item, the Committee:

- Welcomed the clearer line of sight between strategic objectives, principal risks, controls and sources of assurance, noting that further refinement of individual components would continue through the Committee cycle prior to consideration by the Board.
- Noted concerns that, whilst the framework evidenced organisational activity and progress against agreed actions, there was less emphasis on demonstrating organisational impact, measurable outcomes, realised benefits and improvements experienced by patients, service users and communities.
- Recognised that Committee reports frequently provided assurance regarding activity, compliance and process delivery, but less often demonstrated whether the intended outcomes and benefits had been achieved.
- Emphasised the importance of strengthening outcome measures and benefit realisation arrangements to support a more comprehensive assessment of progress against strategic objectives and the impact of improvement activity.
- Noted that demonstrating impact and benefit realisation was an increasing focus both locally and nationally, and that these themes would be explored further through the Board Development Programme with the Good Governance Institute and future Structured Assessment work.
- Acknowledged that, whilst the revised Board Assurance Framework represented a significant improvement and provided a more mature basis for strategic assurance, further development was required to strengthen assurance relating to outcomes, benefits realisation and delivery of strategic objectives.

The following actions were agreed:

- **AC26.78.01** Director of Corporate Governance to reflect the Committee's observations regarding outcomes and benefits realisation when presenting the Board Assurance Framework to Board.
- **AC26.78.02** Director of Corporate Governance to share the updated Structured Assessment brief when received from Audit Wales

It was resolved that the Committee

- **NOTED** the emerging assurance position and identified assurance gaps.



- **ENDORSED** the actions required to complete validation of Risks 26/04 and 26/05.
- **SUPPORTED** further development of assurance reporting arrangement

AC26.79 Corporate Governance Report

The Committee received the report.

In discussing the item, the Committee:

- Noted the positive outcomes of the Committee Self-Assessment for 2025/26 whilst recognising opportunities to further strengthen assurance, risk oversight and strategic scrutiny.
- Considered the proposed revisions to the Committee's Terms of Reference, including the proposal to rename the Committee as the **Audit, Risk and Assurance Committee**.
- Noted that similar developments were taking place across NHS Wales and that the proposed changes more accurately reflected the Committee's responsibilities for risk management, assurance and governance oversight.
- Acknowledged that the proposed expansion of the Committee's remit would increase the volume and breadth of work considered by the Committee.
- Agreed that the proposed changes represented an appropriate evolution of the Committee's role and would support a more comprehensive approach to assurance and oversight.
- Emphasised the importance of maintaining strategic focus and ensuring that the Committee's work complemented, rather than duplicated, the responsibilities of other Board Committees and governance forums.
- Noted progress against the Corporate Governance Improvement Plan and the continued development of the Committee's governance and assurance arrangements.
- Supported the proposed Committee Cycle of Business for 2026/27 and endorsed the revised Terms of Reference, including the proposed change of name, for onward consideration by the Board.

Members resolved that the Committee

- **NOTED** the report
- **NOTED** the outcome of the Committee Self-Assessment 2025/26.
- **APPROVED** submission of the revised Terms of Reference to the Board, noting the proposed change of name to the Audit, *Risk and Assurance* Committee.
- **APPROVED** the Committee Annual Report 2025/26 for submission to the Board.
- **APPROVED** the Committee Cycle of Business 2026/27.
- **NOTED** progress against the Corporate Governance Improvement Plan
- **AGREED ACTION:**
- **AC26.79.01** Outcomes from the Committee Self-Assessment to be reviewed within a future Committee Development Session.

AC26.80 Integrated Compliance and Assurance Report

The Committee received the report.

In discussing the item, the Committee:

- Welcomed the redesigned report and the greater emphasis on assurance, noting that the revised approach provided a clearer assessment of the organisation's overall compliance position and areas requiring further improvement.
- Recognised the significant progress made during the preceding twelve months in strengthening compliance systems, governance arrangements and oversight mechanisms, whilst acknowledging that a number of areas continued to require focused management attention.
- Noted the progress made in reducing historic recommendations and strengthening accountability for delivery, whilst recognising ongoing challenges relating to the timeliness of implementation and evidencing full compliance.
- Supported the introduction of Director Accountability Statements as a means of strengthening ownership of compliance responsibilities and enhancing the system of internal control.
- Acknowledged the significant progress achieved in reducing the number of overdue policies but noted that policy compliance remained an important area of governance risk, particularly where policies related to patient safety, statutory obligations or regulatory requirements.
- Noted the establishment of the Governance and Regulatory Group to oversee a risk-based approach to Welsh Health Circulars and Ministerial Directions and recognised that further work was required to strengthen evidence gathering and assurance arrangements.
- Discussed concerns regarding historic Ministerial Directions and agreed that there would be value in considering how older Directions could be reviewed as part of future compliance work. Members noted that Internal Audit would shortly commence a review of Ministerial Directions, including consideration of historical requirements.
- Noted that compliance reporting would continue to be presented through relevant Board Committees to provide additional oversight and scrutiny.
- Welcomed the clarity of the report but highlighted the importance of ensuring that the status of outstanding Unsatisfactory and Limited Assurance recommendations remained current and clearly reflected revised implementation timescales and progress achieved.
- Emphasised the need to re-baseline long-standing audit recommendations where appropriate to ensure realistic delivery expectations and meaningful performance monitoring.
- Noted that accountability for implementation rested with responsible Directors and that established escalation arrangements existed for overdue recommendations.
- Considered the relationship between compliance activity and benefits realisation and welcomed ongoing work to develop a formal benefits realisation framework to strengthen future assurance reporting.
- Recognised that the organisation had made substantial progress in strengthening compliance arrangements but agreed that assurance relating to implementation, evidence, timeliness, sustainability and embedded learning should remain key areas of focus during the coming year.

- Highlighted risks associated with non-compliance with Ministerial Directions and regulatory requirements, governance and patient safety vulnerabilities arising from overdue policies, and the potential failure to fully embed lessons identified through audits and reviews across the organisation.

The following Actions were agreed:

- AC26.80.01** Director of Corporate Governance to provide the October Audit Committee with an updated position statement on all open Unsatisfactory Assurance and Limited Assurance recommendations, including revised completion dates and progress achieved.
- AC26.80.02** A prioritised report on overdue policies, highlighting those with patient safety, statutory or regulatory implications, to be presented to a future meeting.
- AC26.80.03** Governance and Regulatory Group to consider arrangements for reviewing historic Ministerial Directions and identifying any significant outstanding compliance requirements.

It was resolved that the Committee

- NOTED** the report and current statutory compliance assurance position.
- RECEIVED** assurance regarding the actions being taken to strengthen compliance and governance arrangements.
- APPROVED** the closure of audit recommendations identified within Appendix 1.

Dr Pamela Johnston left the meeting

AC26.81 Governance and Accountability Framework – Amendments

The Committee received the report noting that the review had been undertaken following recent executive changes and to address issues identified through the operation of the Scheme.

In discussing the item, the Committee:

- Noted that the majority of amendments sought to improve clarity, consistency and operational effectiveness rather than alter existing decision-making authorities.
- Recognised that the proposed changes would support more efficient decision-making, provide greater clarity for officers exercising delegated authority and reduce unnecessary operational delays.
- Noted that the proposed amendments had been considered and supported by the Executive Team.
- Highlighted the importance of ensuring that expenditure or projects could not be artificially divided to circumvent approval thresholds and sought assurance that appropriate safeguards were in place.
- Agreed that the Scheme should continue to contain clear provisions preventing the inappropriate splitting of expenditure or projects to avoid approval and escalation requirements.
- Noted a minor drafting amendment relating to Chief Executive delegated limits and agreed that the wording should be amended to reflect approval levels "up to but not including" Board approval thresholds.
- Concluded that the revised Scheme would strengthen governance arrangements and support the consistent application of delegated authority across the organisation.

- Supported the proposed amendments to the Scheme of Reservation and Delegation, subject to the agreed drafting amendment, for onward consideration by the Board.

The following actions were agreed:

- AC26.81.01** Director of Corporate Governance to incorporate the Committee's observations regarding approval thresholds and addressing cost splitting to avoid thresholds being surpassed prior to Board submission.

It was resolved that the Committee

- APPROVED** the proposed changes to the Scheme of Reservation and Delegation for onward submission to Board subject to amendments as agreed in the actions

AC26.82 Committee Assurance report - Alert, Assurance and Advice reports

In discussing the item, the Committee:

- Welcomed the introduction of the Committee Assurance Report and recognised its role in strengthening assurance flows between Board Committees, the Audit Committee and the Board.
- Noted that the report provided a consolidated overview of assurances, concerns and key themes arising from Board Committees and supported a more coherent assessment of the organisation's overall assurance position.
- Recognised the recurring themes emerging from Committee discussions, including risk management and risk reduction, delivery of transformation and improvement programmes, workforce capacity and resilience, governance effectiveness, and benefits realisation.
- Reaffirmed that the Committee's role was not to duplicate the work of other Board Committees but to assess whether assurances provided were robust, interconnected and sufficient to support Board assurance.
- Discussed the extent to which current governance arrangements provided visibility of assurance activity across Committees and noted the importance of strengthening integration and assurance flows across the governance framework.
- Noted concerns regarding variation in the quality and consistency of Alert, Assurance and Advice (AAA) reporting and welcomed the development of guidance to support a more standardised approach across Board Committees.
- Considered the alignment of Committee meeting schedules and recognised the importance of ensuring that Audit Committee meetings were appropriately timed to receive and consider assurance from other Board Committees prior to Board meetings.
- Acknowledged that the report represented an important development in the organisation's assurance arrangements and agreed that the format and content should continue to evolve in response to Committee feedback and organisational learning.
- Considered the level of assurance the Committee was able to provide to the Board and **approved** the proposed Assurance Statement for inclusion within Board reporting

The following actions were agreed:



- **AC26.82.01** Director of Corporate Governance to develop and implement a standardised AAA reporting framework across Board Committees.
- **AC26.82.02** Committee calendars to be reviewed to strengthen assurance flows into Audit Committee and Board.

It was resolved that the Committee

- **NOTED** the thematic review of Board Committee AAA reports.
- **CONSIDERED** the level of assurance it was able to provide to Board.
- **APPROVED** the proposed Assurance Statement for reporting to Board.

AC26.83 Financial Conformance Report

The Committee received the Financial Conformance Report and considered the Health Board's performance against key financial governance indicators. In discussing the report, the Committee:

- Noted performance in relation to No Purchase Order, No Pay compliance, Single Tender Actions, debtor management, payroll overpayments, Public Sector Payment Policy compliance, and Losses and Special Payments.
- Noted that the number of invoices processed without purchase orders had reduced compared to previous years but expressed concern regarding the increase in exceptional "file note" approvals and the need for further scrutiny of these arrangements.
- Received assurance that debtor balances remained recoverable and that appropriate provisions had been established within the accounts.
- Discussed trends relating to clinical negligence and Losses and Special Payments, recognising the value of reporting that provided greater insight into underlying causes, service areas and lessons learned to support organisational learning and committee scrutiny.
- Noted the commitment to share the Legal Services report presented to the Quality, Safety and Experience Committee with members for information.
- Discussed workforce overpayments and procurement compliance, highlighting the importance of training, accountability and management oversight in reducing avoidable exceptions.
- Noted the importance of continuing to promote procurement compliance and awareness amongst budget holders and managers.
- Received assurance that financial control arrangements remained broadly effective, payroll overpayment numbers were reducing, debtor recovery processes remained active and Public Sector Payment Policy performance remained strong.

The following Actions were agreed:

- **AC26.83.01** The Executive Finance Director to undertake further analysis of file-note expenditure and provide an update to the next Committee.
- **AC26.83.02** Future reports to include additional information regarding trends and contributory factors associated with clinical negligence and special payments.
- **AC26.83.03** Director of Corporate Governance to share Legal Services report to QSE Committee with members for information.

It was resolved that the **Committee**

- **NOTED** and **APPROVED** the Financial Conformance Report.

AC26.84 Item deferred

INTERNAL AUDIT

AC26.85 Internal Audit Progress Report

The Committee received the Internal Audit Progress Report covering activity undertaken between April and July 2026. In discussing the report, the Committee:

- Noted progress against the approved Internal Audit Plan and approved amendments to planned audit work, including the deferral of the Research and Development Review and the revision of the Culture Review to an advisory review.
- Considered the findings arising from completed audits and advisory reviews, including a number of Limited and Unsatisfactory Assurance opinions.
- Expressed particular concern regarding the Non-Digital, Data and Technology (DDaT) Controlled IT review, noting weaknesses in the governance, ownership and management of software and digital systems operating outside formal DDaT arrangements.
- Recognised the cyber security, information governance and operational risks associated with unmanaged digital applications and requested realistic timescales for delivery of improvement actions.
- Discussed the Unsatisfactory Assurance opinion relating to the Nuclear Medicine Consolidation Project and noted the significant risks associated with affordability, governance arrangements, delays and approval processes.
- Noted that oversight of the Nuclear Medicine Consolidation Project would continue through the Performance, Finance and Information Governance Committee.
- Discussed the Capital Governance Arrangements Review and noted recurring governance themes identified in previous reviews, particularly in relation to programme governance, business case development, benefits realisation and organisational learning.
- Acknowledged concerns regarding the organisation's ability to embed learning from previous audits and reviews and avoid the repetition of historic governance weaknesses.
- Noted the Chief Executive's comments regarding the importance of strengthening capital governance arrangements in light of the organisation's future capital investment and service transformation ambitions.
- Noted the Head of Internal Audit's view that he did not currently have sufficient confidence in capital governance arrangements going forward.
- Received assurance that improvement plans were in place, implementation would be overseen through relevant Board Committees and further governance review work was being progressed.
- Noted that the Capital Governance Arrangements Review would be considered further by the Executive Committee. Following consideration at the Performance, Finance and Information Governance Committee (PFIGC) an assurance update would be provided to a future meeting of the Audit Committee.

The following Actions were agreed:

- **AC26.85.01** PFIGC to receive and scrutinise recovery plans relating to Nuclear Medicine Consolidation and Capital Governance Arrangements.
- **AC26.85.02** Director of Corporate Governance would liaise with the Acting Director DDaT to consider further whether dates set out in the Non-DDaT IT review were realistic and achievable.
- **AC26.85.03** Assurance update on the Capital Governance Arrangements Review to be discussed further at a future meeting.

It was resolved that the Committee:

- **NOTED** the report and the progress against the Internal Audit Plan.
- **APPROVED** the proposed amendments to planned audit work.
- **RECEIVED ASSURANCE** that improvement plans and governance oversight arrangements were in place in response to identified audit findings.
- **REQUESTED** a further update on Capital Governance Arrangements and progress against actions arising from the Non-DDaT Controlled IT and Nuclear Medicine Consolidation Project reviews.
- **APPROVED** amendments to the Internal Audit Plan.

Martyn Lewis, Paul Stocker and Stuart Keen left the meeting

This agenda item was taken out of sequence in order to accommodate operational availability of the Chief Executive

AC26.88 Centre for Mental Health and Society Internal Advisory Review and Wider Research, Development and Innovation Review

The Committee received the report regarding the review of the Health Board's historic relationship with the Centre for Mental Health and Society (CfMHS). In discussing the report, the Committee:

- Noted that the item had been brought forward following correspondence received from a member of the public who had raised concerns regarding the Health Board's historic relationship with CfMHS and had requested that previous correspondence be brought to the Committee's attention.
- Received a report from the Chief Executive, who advised that she had personally committed to reviewing the matter following discussions with the individual concerned and was presenting her conclusions in her capacity as Accountable Officer.
- Noted that concerns regarding the relationship with CfMHS had been raised several months previously and had been subject to extensive correspondence, investigation and review before the matter was brought to the Committee.
- Heard that, following difficulties securing a suitably independent external reviewer, Internal Audit had been commissioned to undertake the review due to its detailed organisational knowledge and ability to examine historical arrangements and available documentary evidence.
- Noted that, whilst some records relating to arrangements established during the early years of the Health Board were no longer available, sufficient evidence had been identified to enable informed conclusions to be reached.
- Considered the Chief Executive's view that the findings should not be viewed in isolation, but rather within the context of wider historical governance challenges

experienced by the organisation, including issues relating to procurement, contract management, governance, assurance and Research, Development and Innovation (RD&I) arrangements.

- Noted that the period under review coincided with a time when Mental Health services faced significant operational and governance challenges and recognised the importance of considering the historical context within which the arrangements had operated.
- Heard that Mental Health services were now subject to ongoing scrutiny and improvement oversight through established Board and Committee arrangements and that lessons arising from the review formed part of a broader programme of organisational learning and continuous improvement.
- Discussed the importance of research activity to healthcare improvement and noted the Chief Executive's view that Research, Development and Innovation formed a fundamental component of a high-performing healthcare organisation.
- Noted that partnerships with universities and research institutions were important to supporting innovation, service development and improved patient outcomes and should continue to be actively encouraged.
- Recognised that the principal issue arising from the review was not whether research partnerships should exist, but whether the governance, accountability and assurance arrangements surrounding those partnerships had been sufficiently robust.
- Noted that the review had identified a number of recurring governance themes, including honorary contract arrangements, declarations of interest, partnership governance, financial approval processes and arrangements where individuals worked across organisational boundaries.
- Heard that improvements had already been made across a number of these areas in recent years but that further strengthening of governance arrangements would continue as part of wider organisational improvement work.
- Received assurance that broader concerns relating to RD&I governance had already been identified by the Executive Medical Director and that a wider review of RD&I governance had been commissioned.
- Noted that findings arising from the CfMHS review would be incorporated into the wider RD&I review to ensure that lessons learned were reflected in future arrangements.
- Heard that the wider review would consider how partnerships are established, governed, monitored and assured, with the objective of strengthening accountability and oversight whilst continuing to support innovation and research activity.
- Discussed concerns raised regarding the use of public funds and received assurance that specialist advice had been sought from NHS Counter Fraud Services as part of the review process.
- Noted that Counter Fraud advice had been considered alongside Internal Audit findings and wider governance evidence before conclusions were reached.
- Received assurance from the Chief Executive that, having considered all available evidence and specialist advice, she was satisfied that there was no evidence of misappropriation of public funds associated with the arrangements under review.
- Supported the conclusion that this aspect of the matter could now be considered closed.

- Noted Rhian Watcyn Jones' observation that individual concerns often act as a catalyst for identifying wider systemic weaknesses and opportunities to strengthen organisational governance arrangements.
- Agreed that the review had highlighted broader governance lessons beyond the specific circumstances of the CfMHS arrangements.
- Heard from the Director of Corporate Governance that the matter had been particularly complex and sensitive and had taken longer than anticipated to conclude.
- Noted that significant efforts had been made to secure an independent reviewer before Internal Audit was commissioned and received assurance that appropriate due diligence had been undertaken throughout the process.
- Received assurance that draft Internal Audit findings had initially been reviewed by Counter Fraud Services and that, following changes in leadership arrangements within Counter Fraud, a further review had subsequently been undertaken by the Head of Counter Fraud Services Wales.
- Noted that the concerns and findings had therefore been subjected to scrutiny and challenge through more than one independent review process.
- Noted the Director of Corporate Governance's thanks to Internal Audit colleagues, Counter Fraud Services and governance staff for their support and professionalism throughout what had been a prolonged and sensitive review.
- Acknowledged the observation that investigations of this nature can have a significant impact on individuals and agreed on the importance of conducting such work with fairness, professionalism and compassion.
- Noted comments made by the Board Chair, who reflected that the issue represented one of a number of legacy matters inherited by the organisation and highlighted the importance of recognising the contribution made by the member of the public in raising the concerns.
- Agreed that the investigation demonstrated that concerns raised externally could be appropriately considered and addressed through established governance arrangements.
- Noted the Board Chair's view that research and innovation should remain a strategic priority for the Health Board and that opportunities arising through partnerships with Bangor University, Wrexham University and other research and innovation partners should continue to be developed.
- Discussed the potential benefit of providing the Board and Committees with greater visibility of the organisation's wider research agenda, partnerships and programmes.
- Noted the Board Chair's observation that governance weaknesses established at the outset of arrangements can persist for many years if not addressed promptly and that the review reinforced the importance of strong governance, accountability and assurance arrangements from the commencement of any partnership or programme.
- Agreed that external scrutiny can provide valuable challenge and organisational learning and welcomed the opportunity to use the findings from the review to strengthen future governance arrangements.
- Welcomed the intention to address the remaining governance themes identified through the review as part of the wider review of Research and Development governance.

The following Actions was agreed:



- **AC26.88.01** that the resulting improvement plan from the wider R&D review is reported back through the appropriate governance route, with clear ownership, milestones, target dates and residual risk assessment.

It was resolved the Committee:

- **NOTED** the Chief Executive's assessment of the findings arising from the Internal Audit Advisory Review of the Centre for Mental Health and Society (CfMHS), including the governance, financial control, value for money and assurance issues identified.
- **NOTED** the management actions completed or underway, including financial reconciliation, strengthened invoice approval controls, declarations of interest compliance work, honorary contract review arrangements and the review of the Academic Partnership Board Terms of Reference.
- **ACKNOWLEDGED** that a number of management actions are dependent on the wider Review of Research and Development (R&D) Governance, which has now been commissioned and will include CfMHS as a specific line of enquiry.
- **RECEIVED ASSURANCE** that interim controls remain in place pending completion of the wider review, including controls relating to invoice approval, duplicate funding checks, declarations of interest, honorary contracts and future contractual and partnership arrangements.

AC26.86 External Audit Progress Report

The Committee received the Audit Wales Update Report. In discussing the report, the Committee:

- Noted that the 2025/26 Financial Statements Audit had been completed.
- Noted progress in the ongoing reviews of Cancer Services and the Management of Estates.
- Noted that work had commenced on the Foundations for the Future and Primary Care follow-up reviews.
- Received an update on planning for Structured Assessment 2026 and noted that the scope continued to evolve.
- Noted the expectation that Structured Assessment 2026 would place greater emphasis on benefit realisation and organisational impact.
- Received assurance that the Audit Wales programme remained on schedule and that planned work was progressing as expected.

It was resolved that the Committee:

- **NOTED** the Audit Wales Update Report and the progress of the Audit Wales work programme.
- **RECEIVED ASSURANCE** that the Audit Wales programme remained on schedule and that planning for Structured Assessment 2026 was progressing.

COUNTER FRAUD

AC26.87 Local Counter Fraud Service Progress Report



Danielle Timmins, Head of Local Counter Fraud, presented the report outlining delivery against the Counter Fraud Work Plan.

In discussing the report, the Committee:

- Noted progress against the Counter Fraud Workplan for 2026/27 and the breadth of activity undertaken to support fraud prevention, investigation and awareness across the organisation.
- Discussed how the impact and effectiveness of Counter Fraud activity could be demonstrated more clearly through future reporting.
- Noted Rhian Watcyn Jones' observation that whilst the report reflected significant activity, greater emphasis on organisational outcomes, financial benefits, cost avoidance and lessons learned would strengthen assurance.
- Received clarification that measuring the impact of preventative activity remained challenging, particularly where losses had been avoided rather than recovered, although work was underway to develop methodologies for quantifying the value of fraud prevention interventions and wider awareness activity.
- Welcomed the proposal for Counter Fraud reporting to become a regular agenda item for the People and Culture Committee, recognising the important link between fraud prevention, organisational culture and staff awareness.
- Noted the risks associated with workforce fraud, payroll fraud, sickness fraud and financial losses arising from ineffective preventative controls.
- Received assurance that Counter Fraud activity remained on track, national priorities were reflected in local work plans and fraud prevention arrangements continued to strengthen.
- Agreed with the Committee Chair's observation that preventative fraud work was inherently difficult to quantify but remained a critical component of organisational control and should continue to be reinforced through training, awareness and culture.
- Noted the Executive Director of Finance's commitment to consider the Committee's comments further with the Head of Local Counter Fraud.

The following Action was agreed:

- **AC26.87.01:** Executive Director of Finance to meet with the Head of Local Counter Fraud to consider opportunities to strengthen outcome-based and measurable reporting of Counter Fraud activity.

It was resolved that the Committee:

- **NOTED** progress against the Counter Fraud Workplan for 2026/27.
- **RECEIVED ASSURANCE** that Counter Fraud activity remained on track and that fraud prevention arrangements continued to strengthen.

CLOSING BUSINESS

AC26.89 Agree Items for referral to Board / Other Committees Chair

Appropriate referrals were in place through established governance arrangements in regard to Internal Audit Reviews.

AC26.90 Review of meeting effectiveness

In reflecting on the meeting, the Committee:

- Reflected positively on the breadth of business conducted and the quality of discussion throughout the meeting.
- Recognised the continued development of the Committee towards a stronger Audit, Risk and Assurance function.
- Welcomed the increasing emphasis on organisational assurance, outcomes and effectiveness, rather than solely assurance regarding the completion of processes and controls.
- Acknowledged the importance of continuing to strengthen reporting in relation to benefits realisation, organisational learning, risk reduction and the impact of improvement actions.
- Noted Rhian Watcyn Jones' observation that the decision to reorder the agenda to accommodate the availability of the Chief Executive had been reasonable in the circumstances but may have affected members of the public wishing to observe the discussion on the Centre for Mental Health and Society Review.
- Received assurance that comprehensive minutes of the discussion would be made available to support transparency and public accountability.
- Noted the Chair's conclusion that the Committee had undertaken a substantial programme of work and had continued to provide constructive challenge, scrutiny and assurance across a broad range of governance, risk and control matters.

The Committee noted the reflections and learning arising from the meeting.

AC26.91 Date of the next meeting : 20 October 2026

Resolution to exclude the Press and Public

"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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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Audit Committee Action Log (Public)

Updated 13.10.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
REMAIN OPEN						
1	AC26.77.01	18.8.26	Corporate Risk Register Report Bring forward proposals to strengthen oversight and reporting of risks above Board appetite, aligned to IMTP delivery	Director of Corporate Governance	End December 2026	Remain open Not yet due
2	AC26.80.01	18.8.26	Integrated Compliance and Assurance Report Director of Corporate Governance to provide the October Audit Committee with an updated position statement on all open Unsatisfactory Assurance and Limited Assurance recommendations, including revised completion dates and progress achieved.	Director of Corporate Governance	1.12.26	Remain open Head of Statutory Compliance and Inquiries to include in subsequent reports from December meeting
3	AC26.80.02	18.8.26	Integrated Compliance and Assurance Report A prioritised report on overdue policies, highlighting those with patient safety, statutory or regulatory	Director of Corporate Governance	1.12.26	Remain open

			implications, to be presented to a future meeting.			
4	AC26.80.03	18.8.26	Integrated Compliance and Assurance Report Governance and Regulatory Group to consider arrangements for reviewing historic Ministerial Directions and identifying any significant outstanding compliance requirements.	Director of Corporate Governance	16 February 2027 meeting	Remain open Head of Statutory Compliance and Inquiries to address in Corporate Governance Improvement Plan and report in the Integrated Compliance report by March 2027
5	AC26.81.01	18.8.26	Governance and Accountability Framework Amendments Approval thresholds shall be applied to the total value of a project, programme or procurement. Costs must not be divided or phased to avoid the appropriate approval route.	Director of Corporate Governance	31.11.26	Remain open Head of Corporate Governance to address within the Corporate Governance Report to the Health Board
6	AC26.82.01	18.8.26	Committee Assurance report - Alert, Assurance and Advice reports To introduce a standardised AAA reporting framework across Board Committees and report on implementation progress to the Committee	Director of Corporate Governance	31.9.26	Remain open The Corporate Governance Team are working on this, this will be reflected in the next AAA reports.
7	AC26.82.02	18.8.26	Committee Assurance report - Alert, Assurance and Advice	Director of Corporate Governance	April 2027	Remain open Head of Corporate Governance to address in next Corporate

			reports Committee calendars to be reviewed to strengthen assurance flows into Audit Committee and Board.			Calendar to be issued – wef April 2027
8	AC26.83.01	18.8.26	Financial Conformance Report The Executive Director of Finance to undertake further analysis of file-note expenditure and provide an update to the next Committee.	Executive Director of Finance	31.11.26	Remain open
9	AC26.83.02	18.8.26	Financial Conformance Report Future reports to include additional information regarding trends and contributory factors associated with clinical negligence and special payments.	Executive Director of Finance	31.11.26	Remain open
10	AC26.85.02	18.8.26	Internal Audit Progress Report Director of Corporate Governance would liaise with the Acting Director DDaT to consider further whether dates set out in the Non-DDaT IT review were realistic and achievable.	Director of Corporate Governance	DGC to advise appropriate timeline	This audit covers a number of lead directors and confirmation has been sought that the timescales set are appropriate.
11	AC26.85.03	18.8.26	Internal Audit Progress Report Following scrutiny at PFIGC, assurance update on Capital Governance Arrangements Review	Executive Director of Finance	1.12.26	

			to be discussed further at a future meeting			
12	AC26.87.01	18.8.26	Counter Fraud report Executive Director of Finance to meet with the Head of Local Counter Fraud to consider improvements to measurable reporting	Executive Director of Finance	31.11.26	Remain open
13	AC26.68	26.6.26	Head of Internal Audit (IA) Opinion & Annual Report 2025/26 Action: Consider digital governance oversight, structures and reporting arrangements at a future Committee meeting.	Acting Director Digital Data and Technology	October 2026	In progress The Digital Data Review will report through to Audit Committee in due course
14	AC26.4.2	17.2.26	Matters arising Address realistic timing of when the Committee actions are due via the Chairs Advisory Group	Director of Corporate Governance	31.10.26	In progress 18.8.26 Head of Corporate Governance to circulate protocol to members of CAG 09.04.26 This will be added to the 2.6.26 agenda for CAG where it was agreed to develop a short protocol. This is in draft and has been shared with Committee Chairs To be shared with the CAG on 28.10.26
ACTIONS PROPOSED FOR CLOSURE						
0	QS26.38.2	0	Transferred action from QSEC: Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	Executive Director Nursing and Midwifery	October 2026	Propose for closure On 20.10.26 ARAC agenda

1	AC26.75	18.8.26	Summary action log To include additional action identified within the minutes	Secretariat	18.8.26	Completed at 1a below
1a	AC26.75	21.4.26	Provide assurance regarding 21.4.26 item : Internal Audit plan 2026-2027, bullet point 3 on page 6 regarding zero-based budgeting readiness and the shift towards primary and community care & partnership working.	Executive Director of Finance	18.8.26	Propose for closure Verbal assurance was provided by the Executive Director of Finance at 18.8.26 meeting
2	AC26.76.01	18.8.26	Update on Outstanding Audit Recommendations - Director of Corporate Governance Director of Corporate Governance to provide a report to the October meeting regarding compliance with Declarations of Interest requirements, including compliance within staff groups holding delegated financial authority.	Director of Corporate Governance	3.10.26	Propose for closure On the 20.10.26 ARAC agenda as per cycle of business : Standards of Business Conduct
3	AC26.78.01	18.8.26	BAF Director of Corporate Governance to reflect the Committee's observations regarding outcomes and benefits realisation when presenting the Board Assurance Framework to Board.	Director of Corporate Governance	10.9.26	Propose Closure This has been reflected in the paper to the Board in September
4	AC26.78.02	18.8.26	BAF Director of Corporate Governance to share the Structured Assessment Brief	Director of Corporate Governance	September 2026	Propose for closure - Completed Shared with the Board

5	AC26.79.01	18.8.26	Corporate Governance Report Outcomes from the Committee Self-Assessment to be reviewed within a future Committee Development Session and priorities for improvement agreed	Director of Corporate Governance	14.9.26 for 28.9.26 AC Development session	Propose for closure - Complete AC Development session 28.9.26
6	AC26.88.01	18.8.26	CfMHS Ensure the resulting improvement plan from the wider RD&I review is reported back through the appropriate governance route, with clear ownership, milestones, target dates and residual risk assessment.	Director Corporate Governance	Sent email to CDay for timeline	Proposed for [AC] closure Transferred to QSEC Executive Medical Director to advise of anticipated timescale
7	AC26.85.01	18.8.26	Internal Audit Progress Report PFIGC to receive and scrutinise recovery plans relating to Nuclear Medicine Consolidation and Capital Governance Arrangements	Executive Director of Finance	30.8.26	Propose for closure Transferred action to PFIGC
8	AC26.83.03	18.8.26	Financial Conformance Report Director of Corporate Governance to share Legal Services report to PFIG Committee with members for information.	Director of Corporate Governance	30.8.26	Propose for closure Complete 1.9.26 Circulated for information to Audit Committee members only. Report is discussed in private session of Committee.
9	AC26.32	23.4.26	Standards of Business Conduct Action: Enhance Declarations of Interest reporting to provide risk-based assurance and clearer analysis of declaration compliance.	Head of Corporate Governance	October 2026	Propose for closure – superseded by further action AC26.76.01 On the Agenda
10	AC26.36	23.4.26	Internal Audit Progress Report Action: Future reports to provide six	Chief Operating Officer	October 2026	Agreed 18.8.26 Transferred to People and Culture

			and twelve-month assurance updates on the implementation and effectiveness of <i>improvements to on-call arrangements</i> .		April 2027	Committee [DD sent 1.9.26 incl for transfer log] Director of Corporate Governance recommends assurance is provided from People and Culture Committee and include as specific agenda items
11	AC24/151.1	05.11.24	Centre for Mental Health and Society (CfMHaS) (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Pam Wenger Russell Caldicott	March 25 May 25 Revised timescale August 26	Propose closure 18.8.26 - Discussed as Agenda item at 18.8.26 meeting 6.7.26 – Agenda item August meeting 09.04.26 This item will be received at the next Audit Committee. An explanation has/will be shared outside of the meeting. 10.3.26 Public session agenda item 21.4.26 09.02.26 On the private agenda for 17.02.26. 27.01.26 Draft internal audit report has been issued to the Health Board for consideration. A meeting is being planned to discuss the findings with key officers. =27.11.25 Audit in progress update to be provided by Head of Internal Audit.



						<p>11.09.25 An update has been provided in the Corporate Governance Report. The procurement of an independent reviewer has been completed and the evaluation report is anticipated to be available for the next meeting in December 2025.</p> <p>27.07.25 An extended deadline of 10 July 2025 was provided and the Health Board has received two expressions of interest. The Corporate Governance Directorate will now progress this in partnership with the Procurement Team with work estimated to commence during August 2025 with an update to Audit Committee planned for October 2025.</p> <p>09.05.25 An independent reviewer has been sought on the procurement portal (since 14.03.25). Currently awaiting expressions of interest to complete the work. A report is due to go to the Committee in June 25 dependant on securing an independent reviewer.</p> <p>04.03.25 In relation to the Centre for Mental Health it has been</p>
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						<p>agreed to commission a review and this will come back to Committee.</p> <p>03.02.25 ToR have now been drafted and awaiting final review before procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement)</p> <p>08.01.25 An evaluation of the CfMHaS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review are currently being finalised in order that procurement for the review can be commissioned.</p>
12	AC25/136.1	21.10.25	<p>Statutory Compliance Report</p> <p>A copy of the documentation in relation to the Major Project Governance and Contractor Management Review to be shared at the next meeting in December 2025.</p>	<p>Pam Wenger Russell Caldicott</p>	<p>Feb 26 April 2026 October 2026</p>	<p>Propose for closure</p> <p>18.8.26 Capital Governance arrangements IA review provided to Committee</p> <p>See AC26.85.03above - Further scrutiny to be addressed at December 2026 meeting</p> <p>09.4.26 This is scheduled to be on the agenda</p> <p>17.2.26 Concern was raised on the delay to presentation of the report however assurance was</p>

						<p>provided that it would be presented to the next meeting.</p> <p>10.2.26 The Report is in the process of being finalised and will be brought through to the next meeting.</p> <p>1.12.25 Chief Executive confirmed at the Board meeting on 27.11.25 that the Commissioning Assurance Framework was in draft.</p>
13	AC25/32.1	04.03.25	<p>Information Governance and Records Management Position</p> <p>The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee.</p>	<p>Pam Wenger Dylan Roberts Justine Parry</p>	<p>Oct 25</p> <p>Revised timescale Apr 26</p>	<p>Propose Closure</p> <p>1.9.26 Director of Corporate Governance advises to be transferred to PPHP Committee [DD emailed action to PPHC and transfer log]</p> <p>12.3.26 JP advises: No progress to date due to staffing resource issues – to be considered through Executive Committee prior to submission when resource available to progress.</p> <p>17.2.26 Noted due to be presented at the next meeting</p> <p>11.09.25 The PFIG Committee received an update on Information Governance and Records Management at their meeting on 26.08.25 - please see link below to the paper and note item</p>



						<p>PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team.</p> <p>29.07.25 A session on records management to take place with the Executive Committee and this will be included on the agenda for a more substantive item at a future meeting.</p> <p>19.03.25 Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee.</p>
Closed Actions (as agreed at meeting on 18.8.26)						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	AC26.68	26.6.26	<p>Head of Internal Audit (IA) Opinion & Annual Report 2025/26</p> <p>Action: Chief Executive to reinforce expectations regarding the timely response to complaints and correspondence by Executive Team members, and to issue a communication to Executive colleagues accordingly.</p>	Chief Executive	August 2026	<p>18.8.26 Agreed to close E-mail sent to all Executive Team Members (agreed with the Head of Internal Audit).</p> <p>Issues of timeliness are escalated to the CEO on a weekly basis by the Director of Corporate Governance</p>

2	AC25/136.2	21.10.25	Statutory Compliance Report Director of Corporate Governance to follow up the progress in relation to the implementation of a Commissioning Assurance Framework outside of the meeting and report back to the Committee.	Russell Caldicott	Feb 26 April 2026	18.8.26 Agreed to close 28.5.26 CAF presented to Board 21.04.26 The Executive Director of Finance and officers advised that delays had arisen due to portfolio changes following the departure of the Director of Performance and Commissioning, with responsibility subsequently transferring into the Finance portfolio. Updated timelines were provided, including confirmation that the Commissioning Assurance Framework was scheduled for consideration by the Executive Committee on 6 May, followed by Board consideration later in May. 09.04.26 This is scheduled to go to be considered at PFIGC and then to Board. 10.3.26 This is scheduled to be dealt with by the Performance, Finance and Information Governance Committee (PFIGC). 17.2.26 Concern was raised on the delay to presentation of the report however assurance was provided that it would be presented to the next meeting. 10.2.26 This now falls under the
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						remit of the Executive Director of Finance. The document is in draft and being worked through by the Executive Lead. 1.12.25 Chief Executive confirmed at the Board meeting on 27.11.2025 that the Commissioning Assurance Framework was in draft.
3	AC26.10.1	17.2.26	Corporate Risk Register (CRR) Staff stress related sickness should also capture and report on 'work related' sickness within future reporting.	Executive Director People Services & OD	August 2026	18.8.26 Agreed to close 11.8.26 The Corporate Risk Team is supporting the Risk Lead to revise the Corporate Risk Register entry following a risk deep dive. The updated entry will be included in the next CRR update. 9.3.26 Jody Evans informs this is being written into the CRR update by the responsible lead.
4	AC26.32	23.4.26	Corporate Governance Improvement Programme Action: Enhance the Corporate Governance Improvement Programme reporting framework to include interim milestones, measurable indicators of progress and clear evidence of improvement throughout the year, with particular focus on overdue policies and Board effectiveness.	Head of Corporate Governance	August 2026	18.8.26 Agreed to close Agenda item Corporate Governance report- August Meeting.
5	AC26.30	23.4.26	Update on Outstanding Audit	Head of Statutory	August 2026	18.8.26 Agreed to close

			Recommendations – EDoF Action: Future updates to focus on evidencing delivery of sustained improvements in oversight and control, with clear milestones, governance routes and appropriately timed internal audit follow-up to provide meaningful assurance on implementation.	Compliance		
6	AC26.68	26.6.26	Head of Internal Audit (IA) Opinion & Annual Report 2025/26 Action: Director of Corporate Governance to provide a breakdown of complaint response rates by Executive portfolio to support Committee scrutiny and oversight.	Director of Corporate Governance	August 2026	18.8.26 Agreed to close The Director of Corporate Governance has received the information from the Head of Internal Audit and shared with the Audit Committee Chair separately
7	AC25.167	17.12.25	Internal Audit Progress Report The Head of Internal Audit to follow up the Learning – Regulatory Reporting (BCU-2526-11) report with the Director of Corporate Governance and re-present to the Committee at a future date.	Head of Internal Audit	May 26	21.4.26 Agreed to close A review will be undertaken as included within Quarter 1 of the 2027/28 internal audit work plan 17.2.26 Remain open 27.1.26 The five agreed management actions have two key milestones for implementation, 31 March 2026 and 31 March 2027 respectively. The key governance action is set for 31 March 2027 implementation; any review prior to this would not capture the required governance

						arrangements being in place. Subject to Audit Committee approval, a review will be undertaken in Quarter 1 of the 2027/28 internal audit plan.
8	AC26.70	26.6.26	Audit Wales progress report Strategic Funding @letter Action: Chief Executive to provide a formal management response addressing the issues raised by the Committee.	Chief Executive	August 2026	Agreed for closure 18.8.26 See Appendix 1 attached – letter from Chief Executive to Audit Wales 4.8.26
9	AC26.66	26.6.26	Financial Annual Accounts 2025/26 Agreed that a high-level recovery plan overview (to include impacts and timelines) be provided to the next Audit Committee (August)	Executive Director Finance	August 2026	Transferred to FOG 20.8.26 The Savings Plan is in progress and has been discussed by the Financial Oversight Group and progress to be reported to the Board in September 2026
10	AC26.67	26.6.26	Draft Annual Report 2025/26 Action: Future complaints performance reports to include forward-looking trajectories and forecasts, benchmarking against comparable organisations, and enhanced analysis of complaint trends, themes, causes and emerging risks to support strategic oversight.	Director of Performance	December 2026	Transferred to PFIGC 20.8.26 For progress to be considered via the Performance, Finance and Information Governance Committee

Audit, Risk and Assurance Committee

Acting Director Digital, Data and Technology update presentation on Open Audit Recommendations and Corporate and Board Assurance Framework Risks



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October 2026

Limited Audit Reports presented:

Report Title / Objective(s)	Year	Total number of report findings	Number limited assurance findings	Number of limited findings implemented / complete	Total number of limited findings open
Digital Benefits and Change	2025	5	3	2	1
Non DDaT Controlled IT	2026	10 (DDaT contributing to 4)	7 (DDaT contributing to 4)	0	7 (DDaT contributing to 4)



Digital Benefits and Change

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
The Benefits Management Framework and governance structure has been shared with the Executive Team in August 2026 and the PPHP Committee in September 2026. These arrangements provide a structured mechanism for reporting and demonstrating the value and benefits delivered by digital projects and programmes beyond individual project governance forums.	Embedding a consistent approach to benefits realisation reporting across all digital programmes and ensuring reporting is routinely incorporated within established governance arrangements.	A Benefits Management Framework and associated governance structure have been developed and presented through Executive and Committee governance arrangements to support oversight and reporting of benefits.	Continue implementation of the Benefits Management Framework and governance arrangements, with routine benefits reporting embedded through agreed governance forums. This action is now closed.



Non DDaT Controlled IT

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Governance, Guidance and Oversight- Recommendations: 1830 - Provision of Guidance, 1831 - Oversight Mechanisms Review of digital policies, procedures and guidance underway. Information Asset Owner (IAO) Network being established and communication drafted to identify system owners and collect system ownership information. Consideration being given to a dedicated Viva Engage community to support guidance and compliance activities.	Incomplete system ownership information across the organisation.	Use of existing Digital, IG and Cyber Champion networks to support engagement and communication.	Continue IAO identification activity and complete governance and guidance work by March 2027 (1831) and March 2027 (1830).
Digital Asset Management and Software Risk- Recommendations: 1835 - Identification of Digital Systems, 1836 - Software Risk Work ongoing to improve identification and ownership of digital systems across the Health Board. DDaT developing an approach to collect and validate information relating to digital systems, applications and services. Investigation of cloud application monitoring solutions continues. Cyber Security Team has written to suppliers who do not hold CE+ certification and supplier cyber posture is reported through the Quarterly Cyber Assurance Report and Cyber Security Risk Assessments.	Limited visibility of cloud-based applications and reliance on supplier action to address CE+ compliance gaps.	Quarterly Cyber Assurance reporting, Cyber Security Risk Assessments and supplier engagement activity are in place.	Continue validation of ownership information, progress Information Asset Register improvement work, undertake risk assessments and continue supplier engagement. Target date March 2027.
Medical Device Security Controls Recommendation: 1838 - Medical Device Passwords The Cyber Team currently reviewing existing IG14 policy for coverage of medical device authentication - suggested changes will be presented the ICT/IG Governance Group for review.	Password management controls need to be incorporated within operational processes and policy requirements.	Review of IG14 Security Policy remains an agreed management action.	Update security policy requirements for Medical Internet of Things devices and evidence implementation by Dec 2026.



Corporate Risks / Board Assurance Risks

Risk Title	Open Date	Target Date	Risk Score	Change in Risk Score	Key Actions to Reduce this risk score	Barriers to implementation / delivery	Risk Appetite
CRR25-04 Modernising Digital Infrastructure to Enable Safe, Integrated Care	21/08/2025	31/03/2029	20	No change (current score remained 20)	Recruit specialist integration and interoperability resources; develop a Clinical Data Repository (CDR); enhance Trust Integration Engine capability for HL7/FHIR messaging; strengthen controls to prevent duplicate patient numbering; implement Health Records Scanning Strategy; deliver Digital Foundations/Essential Services Programme; develop Digital Roadmap; implement workforce planning and development actions.	Legacy systems; fragmented digital architecture; limited interoperability across clinical systems; reliance on paper records; infrastructure resilience gaps; constrained workforce; constrained capital investment.	Quality <15; Current position: Not in Tolerance
BAF24-04 - Failure to Deliver a Modern, People-Centred Healthcare System that is Future Focused (Priority 4D - Digital, Data and Intelligence)	<p>BAF24-04 remains open on the Board Assurance Framework and relates to the risk that the Health Board is unable to deliver a robust, integrated Digital, Data and Intelligence capability due to funding constraints, dependencies on internal and external partners, limited clinical and operational capacity, data quality challenges and legacy technology infrastructure.</p> <p>Current Position: Current risk score: 20 (High). Target risk score: 15. The risk remains above the Health Board's stated risk appetite.</p> <p>Progress to Date: Several Priority 4D actions have been completed, including implementation of data governance audits (4D.3), clinical coding quality dashboards (4D.6), digital skills assessment (4D.13) and completion of the Cyber Assessment Framework (CAF) gap analysis (4D.17). A number of further actions remain in progress, including delivery of the data quality framework (4D.4), AI governance framework (4D.18), Digital Roadmap review (4D.19), and actions to strengthen Board oversight of digital clinical safety, cyber security and information governance risks (4D.20).</p> <p>The Board continues to receive assurance through IMTP monitoring, digital programme governance and reporting arrangements, data quality and governance frameworks, cyber assurance arrangements and independent audit and review activity. This version is much closer to the style used in the other ARA papers and is fully traceable back to the BAF document.</p>						

Audit Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

The transition to an Audit, *Risk and Assurance* Committee reflects an evolving role with continued focus on strengthening assurance to the Board. A development session was held on 26.9.26.

Summary of Business Considered in Private

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

The items below were considered in private at the meeting held on 18.8.26

- Local Counter Fraud Service Progress report - private
- Corporate Risk Register - private

Corporate Governance Improvement Plan

The Corporate Governance Improvement Plan continues to progress, with key developments including implementation of the revised Policy Framework; further development of the Operational Governance and Decision-Making Frameworks;

commencement of the independent Well-Led Review; revised Committee responsibilities; and the transition to a strengthened Alert, Assurance and Advice reporting approach. Together, these actions support more consistent, accountable and effective governance and improve the quality of assurance provided to the Board and its Committees.

The Committee is asked to:

- **NOTE** the summary of business considered in private session to be reported in public.
- **NOTE** progress against the Corporate Governance Improvement Plan

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

IHC	Integrated Healthcare Community
-----	---------------------------------

CORPORATE GOVERNANCE REPORT

1. Y SEFYLLFA SITUATION

- 1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 Y CEFNDIR BACKGROUND

- 3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

4 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

4.1 Summary of Committee Business Considered in Private

- 4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

- 4.1.2 The below items were considered in private at the meeting held on 18.8.26

- Local Counter Fraud Service Progress report - private
- Corporate Risk Register - private

4.2 Audit, Risk and Assurance Committee Development session

- 4.2.1 The transition to an Audit, Risk and Assurance Committee reflects an evolving role with continued focus on strengthening assurance to the Board. A development session was held on 26.9.26 focussed upon improving

- Risk Management and Assurance
- Strategic Direction and the Board Assurance Framework
- Programme Governance
- Regulatory Compliance
- Committee effectiveness

4.3 Corporate Governance Improvement Plan

The Corporate Governance Improvement Plan continues to progress, with the agreed focus remaining on strengthening standards of business conduct, organisational governance and the quality of assurance to the Board and its Committees. Delivery will continue to be aligned with the Board Assurance Framework objective of building an effective and accountable organisation and the wider governance improvement agenda.

The Board approved the revised Policy Framework in July 2026. The framework will now be implemented to establish a more consistent and robust approach to the development, review, approval and management of policies across the Health Board.

An Operational Governance Framework has been developed to clarify governance structures, operational accountabilities, escalation routes and decision-making responsibilities. Senior leaders will be engaged to test and refine the framework, ensuring it is practical, proportionate and aligned with operational requirements before wider implementation.

A Decision-Making Framework has been developed to clarify delegated authority and decision-making responsibilities. The framework will be considered by the Executive Committee during Quarter 3 and, subject to its decision, progressed as a core component of the Health Board's wider governance architecture.

The independent Well-Led Review will commence as a key milestone in the governance improvement programme. Regular updates will be provided to the Audit Committee on progress, emerging findings and delivery of any associated improvement actions, enabling the Committee to maintain oversight and seek assurance.

Committee Structure amendments – the Board approved amendments to the Audit Committee Terms of Reference to include Risk and Assurance. Information Governance oversight has been removed from the Performance, Finance and Information Governance Committee to the Planning, Population Health & Partnerships Committee.

Alert, Assurance and Advice (AAA) reporting is being transitioned. This work aims to strengthen the quality of assurance available to the Board by ensuring that risks, levels of assurance, matters requiring escalation and key decisions are reported in a more consistent and transparent manner across all Committees.

5 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO** **KEY RISKS / MATTERS FOR ESCALATION**

5.1 There are no matters for escalation.

6 ARGYMHELLION RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor
The Committee is asked to:

- **NOTE** the summary of business considered in private session to be reported in public.
- **NOTE** progress against the Corporate Governance Improvement Plan

ASESIAD / ASSESSMENT

Cyswllt â'r Blaenoriaethau Strategol
Link to Strategic Priorities



1. Building an effective organisation

Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:

Yr Egwyddorion Dylunio Design Principles

Simplify, Standardise, and Adopt Best Practices
Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:

Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd
Corporate Risks and Board Assurance Framework

BAF24-01 Building an Effective and Accountable Organisation

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Cydraddoldeb

A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)

Equality

Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)

Do/Yes: ☐

Naddo/No: ☒

Canlyniad/Outcome:

Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:

Not necessary for this report

Do/Yes: ☐

Naddo/No: ☒

Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

Have you considered the Armed Forces Covenant Due Regard Duty?		
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Do/Yes: ☐	Naddo/No: ☒
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Do/Yes: ☐	Naddo/No: ☒
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



PROGRAMME PLAN REPORT

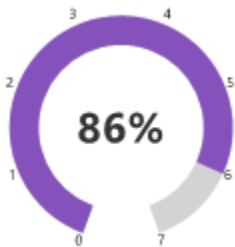
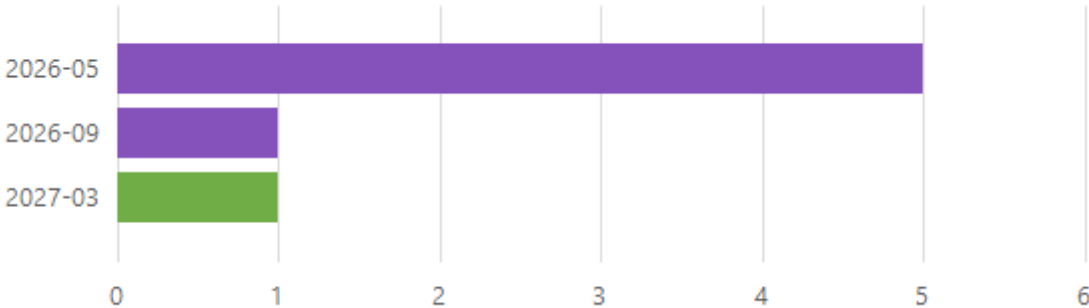


PROGRAMME TITLE: Effective Systems of Governance

Lead: Philippa Peake-Jones (BCUHB - Corporate Office)

SRO: Pam Wenger (BCUHB - Corporate Office)

14/10/26
14:44



Task Owner	Complete	In Progress	Total
Philippa Peake-Jones (BCUHB - Corporate Office)	6	1	7
Total	6	1	7

Workstream	Title	Assigned to	Status	Priority	Due Date	% Complete
Compliance (Reporting, Systems, Processes and Policy Framework)	 The Health Board should ensure that the Board receives Joint Commissioning Committee minutes and related assurance reports to enable it to discuss risks and implications of national commissioning arrangements (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	27/05/26	100%
Governance	 Private Items at Board and Committee (Structured Assessment 2025)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	 The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports) (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	 Induction process for all Board Members (Board Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	29/09/26	100%
	 AAA Reports Publication within 14 days of the (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	 Undertake and Annual Board Self Assessment	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	30/05/26	100%
Standards of Business Conduct	 Ensure all Directors and monitoring arrangements are in place for ensuring staff at Band C and above are completing their declarations of gifts and hospitality, including where such gifts and hospitality are declined (in accordance with the Standards of Business Conduct Policy) (Internal Audit Report)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	30/03/27	0%

Audit , Risk and Assurance Committee

ADRODDIAD CYDYMFFURFIAETH AC SICRWYDD INTEGREDIG INTEGRATED COMPLIANCE AND ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Glesni Driver, Head of Statutory Compliance and Inquiries
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	<p>For assurance</p> <p>For approval closure of the audit recommendations discussed in section 3.2.1.2 and listed in Appendix 1.</p> <p>For noting Public Service Ombudsman report ID 24898 (Appendix 5)</p>

Crynodeb Gweithredol Executive Summary

This report provides the Audit, Risk and Assurance Committee with a comprehensive overview of the Health Board's statutory compliance position and the effectiveness of associated governance, assurance and oversight arrangements. The report brings together information relating to Internal Audit and Audit Wales recommendations, policy compliance, external regulatory activity, and statutory inquiries to support the Committee's consideration of whether appropriate controls are in place to manage compliance risks.

The overall assurance position remains **Limited Assurance**. This reflects a number of continuing governance and control challenges, most notably:

- a significant number of open Internal Audit and Audit Wales recommendations

- delays in implementing and evidencing agreed actions
- a backlog of overdue policies
- continued external scrutiny from regulatory bodies
- the increasing volume and complexity of national compliance requirements.

Whilst progress continues to be made across several areas, including the reduction of open Audit Wales recommendations, improvements in policy compliance performance and ongoing implementation of regulatory improvement plans, assurance remains constrained where implementation cannot yet be fully evidenced or validated.

The cumulative effect of audit recommendations, policy management requirements, regulatory oversight, and emerging inquiry findings continues to place significant demands on organisational capacity and governance arrangements. Continued focus is required to strengthen accountability, improve the pace of delivery and ensure supporting evidence is available to demonstrate sustainable improvement.

Overall Audit Committee Assurance Opinion

The Health Board continues to operate within a complex compliance environment and remains exposed to governance, regulatory and delivery risks in a number of areas. Progress is evident; however, further improvement is required before robust assurance can be provided across all compliance domains.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	23/09/2026	Agreed

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms

HIW	Healthcare Inspectorate Wales
PSOW	Public Services Ombudsman Wales
CIW	Care Inspectorate Wales

ADRODDIAD CYDYMFFURFIAETH AC SICRWYDD INTEGREDIG INTEGRATED COMPLIANCE AND ASSURANCE REPORT

1 Y SEFYLLFA SITUATION

The purpose of this report is to provide the Audit, Risk and Assurance Committee with assurance relating to:

- Internal Audit recommendations
- Audit Wales recommendations
- Policy compliance and governance controls
- Regulatory body reviews and associated improvement actions
- Statutory and public inquiries.

The report is intended to support the Committee in assessing whether appropriate governance, risk management and control arrangements are in place to ensure statutory compliance obligations are being effectively discharged.

2 Y CEFNDIR BACKGROUND

The Health Board is required to comply with a broad range of statutory, regulatory and governance requirements. Compliance is supported through audit activity, regulatory reviews, policy frameworks, performance monitoring and organisational oversight arrangements. Effective assurance is dependent not only upon completion of actions but also on the availability of evidence demonstrating that actions have been implemented, embedded and are operating effectively in practice.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

The Audit, Risk and Assurance Committee is asked to note that the overall compliance position remains subject to **Limited Assurance**, primarily due to the continued backlog of audit recommendations, policy compliance challenges and ongoing regulatory oversight activity.

3.1 Compliance Dashboard

Area	Status	Trend	Key Issue
Internal and External Audit		Stable	High number of overdue recommendations; delays in evidence submission
Policy Compliance		Improving	Improving, but number of policies remain overdue, including patient safety risks
Regulatory Activity (HIW/CIW)		Stable	Improvement plans progressing but some actions overdue
Ombudsman (PSOW)		Improving	Increasing recommendations and sustained investigation levels
National Inquiries		Stable	Ongoing outputs require organisational readiness, and strengthened learning processes.

The principal factors affecting assurance include:

- delays in implementation of audit recommendations
- insufficient supporting evidence to validate action completion
- overdue policies and associated governance risks
- sustained external regulatory scrutiny
- increasing complexity of national compliance requirements.

3.2 Audit

3.2.1 Internal Audit

Internal Audit continues to represent the most significant compliance and assurance challenge facing the organisation. The current position reflects a substantial volume of open recommendations, including recommendations arising from *Limited* and *Unsatisfactory* assurance reviews. A significant proportion remain overdue, with a number exceeding their implementation dates by more than six months.

Whilst progress has been made in advancing recommendations towards closure, assurance continues to be affected by:

- delays in implementation
- incomplete delivery of actions
- insufficient evidence to support closure
- delays in Executive approval and validation processes.

The concentration of recommendations within weaker assurance reports indicates continuing pressure within elements of the Health Board's control environment and highlights the need for ongoing oversight by the Committee.

3.2.1.1 Internal Audit recommendations for closure approval

A total of 56 Internal Audit recommendations are presented to the Audit Committee for final closure approval. These recommendations have been subject to the Health Board's agreed closure process, including approval by the responsible Executive Team Member and subsequent review by the Executive Committee. Where recommendations were within the scope of Internal Audit follow-up activity, closure has been confirmed by Internal Audit, and are now for Audit, Risk and Assurance Committee closure approval. Recommendations that fall outside Internal Audit's review remit are presented directly to the Audit, Risk and Assurance Committee for approval of closure.

3.2.1.2 Limited and Unsatisfactory assurance

A summary of all open *Limited* and *Unsatisfactory* assurance recommendations, including those of high priority are included in Appendix 2 and 3 respectively.

3.2.1.3 Key Assurance Themes

- Significant backlog of overdue recommendations
- Continued implementation delays
- Variable quality and availability of evidence supporting closure
- Increased exposure within *Limited* and *Unsatisfactory* assurance areas
- Progress evident but insufficient to provide substantial assurance.

3.2.2 Audit Wales

The Audit Wales position also reflects ongoing assurance challenges. Whilst the total number of open recommendations has reduced, overdue recommendations remain and progress toward closure continues to depend on the provision and validation of supporting evidence.

The current position limits the Health Board's ability to demonstrate full compliance with external audit expectations and continues to require focused management attention.

3.2.2.1 Audit, Risk and Assurance Committee Assurance View

Based on the volume, age profile and assurance ratings of open recommendations, the audit domain continues to provide **Limited Assurance**. Further progress is required before confidence can be provided that all agreed improvements have been fully embedded and sustained.

A summary of all open Audit Wales recommendations is included in Appendix 4.

3.3 Policy Compliance

Policy compliance remains a key contributor to the overall assurance position. Whilst there has been a reduction in overdue policies compared to previous reporting periods, a backlog remains, including policies with patient safety implications.

Delays in review and approval processes continue to reduce confidence that all policies remain fully current, aligned to legislative requirements and embedded in operational practice.

Work continues to strengthen policy governance arrangements through:

- enhanced policy management processes
- improved tracking and reporting arrangements
- clearer Executive ownership
- strengthened governance oversight.

3.3.1 **Audit, Risk and Assurance Committee Assurance View**

Whilst improvement is evident, the backlog of overdue policies continues to limit assurance regarding the effectiveness of the overall policy framework and supports a **Limited Assurance** assessment.

3.4 **Regulatory Activity**

3.4.1 **Healthcare Inspectorate Wales**

A number of Healthcare Inspectorate Wales (HIW) improvement plans remain active and continue to be monitored through established governance arrangements. Regulatory scrutiny remains focused on patient safety, staffing, quality of care, governance and environmental standards.

During the reporting period, the Health Board responded to several HIW assurance requests relating to emergency care, inpatient services, safeguarding, workforce pressures and governance arrangements. In each case assurance was provided regarding actions undertaken or in progress.

3.4.2 **Care Inspectorate Wales**

Inspection activity continues within the Enhanced Community Residential Service and governance arrangements are in place to oversee implementation of any recommendations arising from future reports.

3.4.3 **Public Services Ombudsman for Wales**

The Health Board continues to demonstrate strong compliance with Ombudsman recommendations, with organisational oversight arrangements supporting implementation and monitoring. Although compliance remains positive, Ombudsman activity continues to generate learning and improvement requirements that require ongoing organisational focus.

3.4.3.1 **Audit, Risk and Assurance Committee Assurance View**

Regulatory activity continues to provide valuable independent assurance regarding service quality, governance and compliance. Whilst progress is evident, ongoing scrutiny and outstanding actions support an overall **Moderate Assurance** assessment.

3.4.3.2 OMBUDSMAN PUBLIC INTEREST REPORT ID 24898

The Ombudsman investigation concerned the care of Mr P at Wrexham Maelor Hospital in March 2024. Mr P sadly passed away in his own home in Shropshire following discharge from Wrexham Maelor hospital. The Health Board received notification of the death following receipt of complaint and coroner's inquest in Shropshire.

The investigation has considered the following:

Mrs P complained about care provided by the Health Board to her late husband. The investigation considered whether:

- It was clinically appropriate to prescribe Sevredol (morphine sulphate) to Mr P
- Mr P and his family were provided with sufficient information and support to minimise the safety risks associated with the prescription of Sevredol.

Both elements of the complaint were upheld.

The investigation identified that:

- A controlled drug (morphine sulphate) was prescribed and issued on discharge, in a way that did not align with the prescriber's original intention
- Expected prescribing and pharmacy safety checks were not completed aligned with policy and process
- The communication and multidisciplinary working between medical and pharmacy teams was poor
- The patient and family were not made aware of the risks of the medication, significantly increasing the likelihood of accidental overdose

The Ombudsman also found that the Health Board's response did not demonstrate sufficient openness and clear identified learning in line with the Duty of Candour, noting this was the second successive report highlighting concerns around the Health Boards openness and transparency approach.

The report (Appendix 5) is being shared with Audit, Risk and Assurance Committee (20.10.26) and Quality, Safety and Experience Committee (2.7.26 in private session) as per recommendations from the Public Ombudsman for noting. The recommendations and actions are being monitored and tracked within the BCUHB Ombudsman Team and governance reporting through Regulation and Governance

3.5 National Inquiries

The Health Board continues to monitor emerging findings from national inquiries, particularly the UK Covid-19 Inquiry and the Thirlwall Inquiry. Governance arrangements are in place through the Discovery and Learning Steering Group to review recommendations, assess implications and coordinate organisational learning.

The findings from the UK Covid-19 Inquiry continue to reinforce the importance of strong governance, resilience, emergency preparedness, supply chain assurance and organisational learning arrangements.

Since the last report, the Thirlwall Inquiry report has been published. The Report highlighted issues relating to governance, effective leadership and oversight, robust safeguarding arrangements, professional accountability, effective escalation of concerns and organisational learning.

3.5.1 Audit, Risk and Assurance Committee Assurance View

Appropriate arrangements are in place to identify and respond to inquiry findings; however, assurance will need to be kept under review as further inquiry reports are published.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

The following continue to present the most significant risks to the assurance position:

- backlog of Internal Audit recommendations
- backlog of Audit Wales recommendations
- delays in closure and validation of audit actions
- policy compliance backlog
- sustained regulatory scrutiny
- organisational capacity pressures arising from competing compliance requirements
- reliance on manual monitoring and variable progress reporting across portfolios.



5 ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp: The Committee/Meeting/Group is asked to:

- **NODI/NOTE** the contents of this report and the current statutory compliance assurance position
- **CYTUNO/AGREE** the closure of the audit recommendations discussed in section 3.2.1.2 and listed in Appendix 1.
- **NODI/NOTE** the Ombudsman Public Interest report ID 24898 as detailed in section 3.4.3.2, per recommendations provided by the Public Ombudsman for noting. The recommendations and actions are being monitored and tracked within the BCUHB Ombudsman Team and governance reporting through Regulation and Governance



ASESIAD / ASSESSMENT		
Cyswilt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	4. Improving quality, outcomes and experience	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not applicable, other than those relating to individual regulatory body reviews and audit reports	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

<p><u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i></p> <p><u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p>Galluogwyr Ansawdd Enablers of Quality Data to Knowledge</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	<p>Meysydd Ansawdd Domains of Quality All Apply</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u></p>	<p>Not Applicable</p>	
<p>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p> <p>No - Not Applicable</p>	
<p>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?</p>	<p>Do/Yes: ☒</p> <p>Canlyniad/Outcome:</p> <p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Naddo/No: ☐</p> <p>No impact</p>



Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

**APPENDIX ONE – SUMMARY OF AUDIT RECOMMENDATIONS FOR
COMMITTEE CLOSURE APPROVAL**

**APPENDIX TWO – SUMMARY OF OPEN INTERNAL AUDIT UNSATISFACTORY
ASSURANCE AUDIT RECOMMENDATIONS, INCLUDING HIGH PRIORITY**

**APPENDIX THREE – SUMMARY OF OPEN INTERNAL AUDIT LIMITED
ASSURANCE AUDIT RECOMMENDATIONS, INCLUDING HIGH PRIORITY**

**APPENDIX FOUR – SUMMARY OF OPEN AUDIT WALES AUDIT
RECOMMENDATIONS**

INTERNAL UDIT RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE APPROVAL

AUDIT RECOMMENDATIONS REVIEWED FOR CLOSURE BY AUDIT BODY, OR ARE OUTSIDE SCOPE FOR REVIEW

ID	Internal Audit/ Audit Wales	Report Title	Year	Overall Report rating - from Jan 2025	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Last update, prior to submission for Audit Body review
0298	Internal Audit	Falls Management	2023	N/A	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.	Angela Wood, Executive Director of Nursing and Midwifery	Patient Handling Training forms part of the mandatory training identified for all staff at the Health Board with more in-depth training i.e. level 2 for identified clinical / patient facing staff. This will be an ongoing action Overall compliance for the Health Board for mandatory training is monitored and reported at various meetings with specific focus on patient safety training via the Patient Safety Group and Executive Quality Delivery Group. Mandatory training will continue to be monitored and reported. Given the size of the Health Board and variable changing influences 100% compliance will not be reached and maintained. Therefore the target is 85%, overall compliance has remained above the target for the last 12 months. The Manual Handling Team are proactively planning ahead with the successful tender to deliver manual handling level 2 training to students to enable continuity of training and assurance that students are trained to the right level prior to commencing their placement within BCUHB.
0454	Internal Audit	Operating Model	2024	N/A	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1(a) The Health Board, through the Chief Executive should undertake a full review of the operating model including: • A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. • A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. • Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. • A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	1.1 (a) The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability. In April 2024, this process is near conclusion. A number of new roles have been advertised publicly on agreed job descriptions and JESP banding with the Welsh Government. These roles will be interviewed in May 2024	Carol Shillabeer, Chief Executive	Whilst initial gap analysis was completed in February 2024 and presented at SOHSG, a revised gap analysis against the NHS employers H&S standards was commenced by Head of Service in February, which informed the strategic plan going forward.
0456	Internal Audit	Operating Model	2024	N/A	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1(c) The Health Board, through the Chief Executive should undertake a full review of the operating model including: • A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. • A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. • Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. • A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	1.1 (c) Areas that have been identified as 'in design' will be considered as part of the wider review noted above, given there may be changes within the structure going forward. Stronger Together was the initial project that supported the change in organisational structures. To ensure we have an integrated approach going forward, a review will take place of the stronger together team and OD team. It is proposed that these teams be merged into one team to provide support to the implementation of any new organisational structure.	Carol Shillabeer, Chief Executive	This work is in progress and the Operating Model Discovery phase is complete. The CEO will now take the findings forward to Board.

0458	Internal Audit	Discharge Arrangements	2024	N/A	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1a: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1a: Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements and the former NU01 BCUHB Hospital Discharge Policy which is out of date. The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation.	Tehmeena Ajmal, Chief Operating Officer	The BCU Hospital Discharge Policy and Protocol has been approved and published
0494	Internal Audit	Health and Safety 2024	2024	N/A	Limited	Medium	Matter Arising 6: Action Plans (Operation)	6.1: Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress	6.1: Estates are ensuring regular internal reviews of H&S for their areas and working on an action plan to ensure that any actions raised are addressed	Stuart Keen, Director of Environment and Estates	Health and Safety meeting took place on 14th August 2024 and action plan reviewed. Health and Safety meetings are held bi-monthly.
0495	Internal Audit	Health and Safety 2024	2024	N/A	Limited	High	Matter Arising 7: Self Assessments (Design)	7.1: A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments	7.1: A calendar has been completed to schedule actual H&S Visits. There is insufficient resource available for the current H&S Advisors to review all self assessments of every department within the health board so the responsibility for management at IHC/Divisional Director needs to be delegated to appropriate persons for review of compliance and escalation to management teams, this will then be reported Quarterly as part of the quarterly report to SOHSG	Carol Shillabeer, Chief Executive	This is an IHC Directors responsibility to ensure that all managers in the service conduct safety assessments, to be included in revised TOR when agreed with Chair of SOHSG/ Environment and Estates Director. •H&S minutes •H&S reports, timetable •P&C Minutes
0528	Internal Audit	Digital Operating Model	2023	N/A	Reasonable	Low	Matter Arising 2: MIOs (Operation)	2.1b: The role of the MIO should be formalised and strengthened with MIOs acting as digital leaders and driving cultural change	2.1b: Working with Digital Health Care Wales nationally and locally to support business change processes and influence this culture change. Formalise and commence delivery to promote the Faculty of Clinical Informatics competences for all MIOs to adopt which will support this cultural change. https://fci.org.uk/work-we-do/professional-competencies.html	Dylan Roberts, Chief Digital and Information Officer	The MIO job description formally establishes the role as a senior clinical digital leader, with clear responsibility for leading and championing DDAT strategy, driving paper-to-digital transformation, influencing clinical culture and behaviours, supporting and challenging clinicians, piloting new technologies in practice, and providing system-wide clinical leadership to enable safe adoption of digital ways of working and sustained cultural change. The Director of digital and I both feel that the current MIO job
0532	Internal Audit	Digital Operating Model	2023	N/A	Reasonable	High	Matter Arising 4: Funding (Operation)	4.1a: The level of funding aligned to Digital should be reviewed to ensure that it matches the organisations stated transformation ambitions.	4.1a: The CDIO and team to present the 2024/25 case (continued repeat of previous year) for the minimum investment requirement to start the transformation of the DDaT operating model to mitigate the major risks and help deliver better outcomes from DDaT enabled change. Executive Management Team agreed that some key posts necessary for the minimum transformation of DDaT could be exempt from the recruitment freeze. However, a larger consideration is yet to be agreed.	Dylan Roberts, Chief Digital and Information Officer	DDaT have been working with finance colleagues to fix historical budget issues and pressures that have not been funded or resolved from previous years that has resulted in a perennial deficit position at the start of every year. At the recent performance review of the service the Executive Director of Finance committed to resolving the main aspects of this to set a base foundation for the budget. This will not fund the required new posts but is a start.
1283	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	N/A	Limited	High	Matter Arising 1: Governance arrangements (Operation)	1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum	1.1: Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (ToR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process.	Tehmeena Ajmal, Chief Operating Officer	Evidence and details for Central IHC provided.
1285	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	N/A	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.1: IHC to ensure that all audits at Tier 1, 2 and 3 are undertaken, and all outstanding responses are received. Findings and lessons learnt must be shared across the IHC and Health Board.	3.1: The Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance will be overseen by QODG.	Tehmeena Ajmal, Chief Operating Officer	This action will be ongoing, with trajectories being measured weekly. These trajectories are also discussed weekly at HMT, with information being escalated via QDG
1286	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	N/A	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.2: IHC Clinical Effectiveness Group (CEG) and Quality Operational Delivery Group (QODG) meetings are aligned appropriately so that CEG meets prior to the QODG to enable the reporting of assurance/matters for escalation in a timely manner.	3.2: The TOR will be reviewed to ensure that this is reflected.	Tehmeena Ajmal, Chief Operating Officer	This action will be ongoing, with trajectories being measured weekly. These trajectories are also discussed weekly at HMT, with information being escalated via QDG

1288	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	N/A	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1: The IHC Director: • Ensures regular member attendance at the Health & Safety and Risk Management Group in order that they and the Senior Management Team receive assurance concerning the review and progression of all risks. • Ensures that all services regularly review their risks in accordance with RM02 Risk Management Procedures - 6.1 registers.	5.1: All services will regularly review their service risks in accordance with RM02 Risk Management Procedures – 6.1 registers. Assurance will be received at the CIHC Health & Safety Risk Management Group. A review of the terms of reference will be undertaken in July 2024 to support regular member attendance.	Imran Devji, Interim Chief Operating Officer	TORs were reviewed at 25 July 2024 meeting and members were asked to give feedback for next meeting - this will be an ongoing process
1309	Internal Audit	Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005	2024	N/A	Reasonable	High	Matter Arising 1: Procedure in place outlines the processes for consultant recruitment (Design)	1.2: Complete and approve the standard operating procedures in line with the requirements set out in the National Health Service (Appointment of Consultants) (Wales) Regulations 1996, as amended by the National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005.	1.2: The new, revised, WP1c Consultant Recruitment Procedure will be submitted to People & Culture Committee for approval by October 2024.	Clara Day, Executive Medical Director	WP1C has been approved via the People Services Policy Development framework. The document published on BetsiNet
1399	Internal Audit	Charitable Funds - 2024	2024	N/A	Reasonable	Medium	Matter Arising 1: Governance and escalation (Operation)	1.1a) The Charity Declaration of Trust is periodically reviewed to ensure continued relevance.	1.1a) The Charity Declaration of Trust is to be reviewed by a legal professional with experience advising charities on their governance and legal structures.	Russell Caldicott, Executive Director of Finance	Went to Board in May 2026 as part of Corporate Governance report
1409	Internal Audit	Charitable Funds - 2024	2024	N/A	Reasonable	Medium	Matter Arising 2: Policy and procedures (Operation)	2.2c) Accountability Agreements are re-established and controls are in place to manage and maintain compliance – we acknowledge that work is currently underway on this issue.	2.2c) All Fund Advisor Accountability Agreements for 2024/25 to be completed and returned to the Charity Support Team, and all Fund Advisors will be required to recommit to the agreement on an annual basis.	Russell Caldicott, Executive Director of Finance	24/25 process complete
1415	Internal Audit	Charitable Funds - 2024	2024	N/A	Reasonable	Medium	Matter Arising 4: Income (Operation)	4.1d) The register of fundraising events is monitored and maintained. Where expected income is not received within the prescribed timescales, this is escalated appropriately.	4.1d) All registered fundraising events are reported into the Charitable Funds Committee on a quarterly basis within the Team update. Fundraising event/ activity will be listed with the date of event; target income; actual income / note on outstanding income; and notes for information	Russell Caldicott, Executive Director of Finance	All fundraising activity is included in the CFC 'Team Update' document created by the Head of Fundraising, this is reported to the CFC quarterly.
1443	Internal Audit	Consultant Job Planning	2024	N/A	Unsatisfactory	High	Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.	7. Evidencing achievement of the Board objectives Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no measurable outcomes agreed from which it could be evidenced as being worked to/achieved.	7. To revisit with Office of the Medical Director the current outcomes section of the job plan and align more fully with the PADR process for other staff groups to ensure objectives can be aligned to allow Consultant & SAS Doctors to support in achieving them.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	Board Outcomes have been input into Allocate
1482	Internal Audit	Network and Disaster Recovery	2024	N/A	Substantial	Medium	Objective 1: The digital infrastructure is maintained with appropriate physical security, monitoring, support, and risk management in place.	R2.4: Physical Security We noted weaknesses in physical security, with a lack of identity checking and challenge and excessive access provided to digital areas within the door access system.	R2.4: Review and re-issue of ICT Security Standard Operating Procedure to all staff.	Dylan Roberts, Chief Digital and Information Officer	ICT Environmental and Physical Security Standard documented
1497	Internal Audit	Establishment Control	2025	Reasonable	Reasonable	Medium	Objective 1: There is a procedure in place for establishment control that clearly outlines the process, responsibilities and monitoring / compliance of the process.	1. Review of procedure The Establishment Control procedure has not been reviewed since 2018 and requires updating to reflect the revised Standing Financial Instructions.	1. The Head of Business Systems and Intelligence (People Services) will undertake a review of the procedure and ensure this is circulated and reviewed with all relevant stakeholders.	Russell Caldicott, Executive Director of Finance	The Establishment control written control document was updated in 2025 and is live on BetsiNet. This is supported with additional materials on the EC pages in relation to the enhanced controls that are currently in place.
1498	Internal Audit	Establishment Control	2025	Reasonable	Reasonable	Medium	Objective 1: There is a procedure in place for establishment control that clearly outlines the process, responsibilities and monitoring / compliance of the process.	2. Audit and monitoring of procedure As per roles and responsibilities within the Establishment Control Procedure (2018), we are unable to evidence that finance "Undertake an audit review with the Establishment Control & Finance Systems team on a quarterly basis to ensure that the core processes are being followed".	2. As the procedure was last reviewed in 2018 and predates the electronic system there is a need to review this requirement as part of the procedure update. The reconciliation is undertaken by the People Systems Team monthly and all individual establishment control requests are reviewed with a read across to the workforce and financial information which ensures no appointments can be made where there is insufficient budget in place.	Russell Caldicott, Executive Director of Finance	The quarterly reconciliation is no longer needed as you can no longer recruit against a negative budget.

1499	Internal Audit	Establishment Control	2025	Reasonable	Reasonable	High	Objective 2: Establishment / budgets are communicated to operational areas and regularly reviewed by management.	3. Accountability Letters One out of the four executive director accountability letters sampled had not been agreed, as required by Health Board Standing Financial Instructions.	3. Meetings have continued to be held to facilitate the ability for the budget holders to feel able to sign off their accountability agreements. The factors which are to be resolved involve financial budgets to match establishment and budget holders to undertake housekeeping on their ESR establishment to negate the need for recharges. This ensures budgets are representative for decision making / recruitment. We will work towards all Executive Accountability Agreements to be signed off by end of February 2025. Of the total 467 budget holders (including Executive Directors), 420 have signed currently.	Russell Caldicott, Executive Director of Finance	Final year to date totals were reported in May 2025 in IPEDG. The signed Accountability Agreements remain at; 90% signed off 8% remain outstanding with reasons not explicit It is a key element of the Internal Audit ask to ensure budgets are received and if not endorsed, the reasons clearly articulated. The 25/26 Accountability Agreements will be circulated as soon as the 25/26 budget is finalised. Item to be put for closure meeting documents attached for evidence.
1524	Internal Audit	Clinical Audit - 2025	2025	Limited	Limited	Medium	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	3. Overdue Service Assessment of Compliance proformas We were unable to observe evidence of escalation emails for overdue SAOCs being sent for two of the three overdue audits we sampled.	3. The Clinical Effectiveness Facilitator (CEF) will as part of the SOP ensure the following will be required: (a) Evidence of email escalations to be saved to the project folder by the CEF team and an update of the SOP to ensure this is part of the process (b) Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced (c) Document evidence of escalations in The Audit Management and Tracking (AMaT) to make the process transparent – this will show which areas have not replied and ensure that this information is captured by the CEF and monitored properly or escalated as necessary	Clara Day, Executive Medical Director	a) All Clinical Effectiveness Facilitators within the team save evidence of escalation of overdue Service Assessment of Compliance forms (SAOCs) in the relevant project folder. b) Quarterly departmental audits are being carried out throughout 2025/2026 to monitor team adherence to this protocol and then reported to monthly Clinical Effectiveness Meeting. c) Evidence of escalations is recorded in AMaT in the notes section so that any non responders can be identified and escalated further to the appropriate Clinical Effectiveness Group.
1525	Internal Audit	Clinical Audit - 2025	2025	Limited	Limited	High	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	4. Escalation process for overdue action plans For Tier 1 audits, when an action becomes overdue, weekly reminder emails are sent to the action owner generated from the AMaT system. If the owner does not respond, there is no escalation process in place to ensure the action is completed.	4. We will develop a process for this, to ensure that moving forward that progress is included with Tier 1 improvement actions and included in the Monthly Assurance report that is sent out to IHCs and Divisions. Need to ensure tighter controls are incorporated in our SOPs and that monitored on regular basis to raise and escalate with actions that are overdue	Clara Day, Executive Medical Director	An internal guide outlining the escalation process and reporting requirements for overdue Tier 1 audit actions has been drafted and agreed following discussion at the departmental meeting in January 2026. This internal guide establishes the escalation steps, monitoring arrangements, and reporting processes to ensure overdue actions are managed consistently and included in the departments Monthly Assurance report
1526	Internal Audit	Clinical Audit - 2025	2025	Limited	Limited	High	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	5. Lessons learnt shared to appropriate forum We have not been able to demonstrate oversight in collecting data on lessons learned/shared and in developing action plans to address issues from Tier 2 audits.	5. Tier 2 audit details have been captured through Strategic CEG updates and within quarterly reports, however going forward there needs to be a more robust process, similar to Tier 1 and Tier 3. A form will be development to roll out from April 2025 to capture learning, where shared and development of actions plans.	Clara Day, Executive Medical Director	The internal guide for Tier 2 audits, aligned with the established Tier 1 process, was implemented in October 2025. This internal guide introduces a structured approach for the registration, monitoring, and completion of Tier 2 audits. The process includes the use of a Service Assessment of Compliance (SAOC) form, which captures assurance & risk levels, key achievements, improvement plans, and learning
1527	Internal Audit	Clinical Audit - 2025	2025	Limited	Limited	High	Objective 5: Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed	6. Overdue Tier 3 audits A large number of Tier 3 audits (183) are overdue with no revised dates of completion. We recognise the clinical effectiveness team have introduced a process to improve completion rates, however Integrated Health Communities (IHCs) and Services are responsible for monitoring their Tier 3 audits, and ensuring the E-tool system is up to date with expected time scales.	6. Prior to the internal audit, we had already development and were getting these steps in place: The Clinical Effectiveness Department emails auditors that have overdue projects, to ask them to update the e-tool (either with an updated completion date, mark as complete by uploading report or mark as abandoned). This has been agreed within the team that once this has been requested 3 times non-progress will be reported through departmental Clinical Effectiveness NICE/Audit Group (CENAG) and will then be raised within IHC/Divisions/Services	Clara Day, Executive Medical Director	The internal guide for managing overdue Tier 3 audits was implemented in April 2025. Since implementation, the escalation and monitoring process has led to significant improvement in the completion and updating of Tier 3 projects. Impact on 2024-2025 registrations : Open Projects reduced from 72.8% (326) on 31st March 2025 to 11.8% (53) as of 16 February 2026. Overdue projects reduced from 56.5% (253) to 10% (45) over the same period. Work is ongoing with 2025-2026 registrations: 56.2% (213) remain open, 24.8% (94) are overdue.

1532	Internal Audit	Board Assurance Framework and Risk Management	2025	Reasonable	Limited	High	Objective 5: There is targeted risk management training available to staff throughout the Health Board, with completion / compliance monitored.	1. No level 1 mandatory training taking place but note an eLearning video has been created and is awaiting upload. We are unable to determine the number of staff who require Level 2 and/or Level 3 training versus those who have received the training. Not all Health Board Members and regular attendees attended the training session on risk management.	1. A new risk management system is being procured, and this will be able to demonstrate all handlers and owners (level 2) requiring training. This will be in place Feb 2026. However, training compliance figures for Level 1 and Level 3 will be shared with the Executive Committee, Directorate, and Divisions, with the support of the Corporate Risk Team. This will facilitate a Health Board-wide approach and ensure commitment	Pam Wenger, Director of Corporate Governance	As of November 2025, 1,671 staff have completed risk management training across all levels. Level 1 compliance is 771 staff (non-mandatory) Risk is also within induction for all new starters. For Level 2, 528 staff are identified as handlers/owners; compliance has improved among this cohort is 72%. For Level 3, 516 staff are required to complete training, including 226 staff at Band 8b and above, with compliance currently at 48% with a minimum of monthly sessions planned to increase compliance. Level 4 Board compliance stands at 88% . The RM03 Risk Management Training Plan has been approved in Nov 25 and scheduled to be updated next year to align with the new competencies framework in Foundations of Future. The training log has been revised and now monthly datasets are aligned from ESR to ensure accurate identification, tracking, and targeted follow-up of staff requiring training.
1533	Internal Audit	Board Assurance Framework and Risk Management	2025	Reasonable	Reasonable	High	Objective 6: There has been progress in implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (BCUHB-2324-19).	2. The quality of Operational Risk Registers continues to be an issue of concern regarding overdue risk review dates and target dates and the lack of alignment of action plans with SMART goals. We note that risk managers audits have highlighted the same issues.	2. Executive Directors, with the support of the facilitation of the Corporate Risk Team, to continue to monitor overdue risk review dates, themes and target dates and the lack of alignment of action plans with SMART goals through audits with an expected an improvement from basic to established in 6 months. Over the next 9 months the Corporate Risk Team with have completed all baseline audits and will be following up on actions to ensure operational risks have SMART actions and good governance in place to ensures risks are regularly reviewed.	Pam Wenger, Director of Corporate Governance	As of March 2025, 19 audit actions assigned to improve the articulation of risk register entries by updating them to meet SMART criteria. Since then, a further 9 actions generated through subsequent baseline audits, bringing the total number of SMART-related housekeeping actions to 28. As at 26 November 2025, 14 actions (50%) completed. The remaining 14 actions (50%) remain open and are being actively monitored through the audit log and Directorate risk governance processes. To support improvement, SMART training has been delivered to all Risk Leads, and a recorded training module is now available on the Risk Leads Channel to ensure consistent access and capability building. Ongoing collaboration with Directorate Risk Leads continues to focus on progressing the remaining actions and improving the quality of operational risk information. Strengthened accountability arrangements have now been implemented: Overdue actions are reviewed and challenged by the Corporate Risk Team, with escalation to Directorate Leadership where required. Where progress remains insufficient, actions are escalated to the Executive Committee. The Chair of the Risk Scrutiny Group has now invited all risk leads with overdue actions to be presented by Directorates alongside their improvement plan at each meeting. This enhanced governance approach has led

1540	Internal Audit	Discretionary Capital Funding Allocation	2025	Reasonable	Limited	High	<p>Objective 2: A risk-based approach is taken to review, scrutinise and prioritise bids for funding.</p> <p>The Head of Capital Development advised that all bids are prioritised by the respective IHC's and regional group Senior Leadership Teams prior to submission. We have been unable to verify this from information provided and subsequently could not establish reason why some potential investments have taken priority over others. We recognise that whilst it is at the Health Board's discretion to allocate the funding, management should demonstrate why some bids have been prioritised over others prior to the development of a business case. This would ensure that the funding is allocated to priority areas.</p>	<p>2. Prioritising Discretionary Capital We requested a list of all schemes not approved for funding to establish reasons for this. Management advise that the Capital programme goes through the approval process detailed and that the Health Board is free to prioritise the sum allocated as it best sees fit and as such different from the Capital programme that requires Welsh Government approval.</p>	<p>2. As a course of action the capital programme follows a prioritisation process before approval. However, it is acknowledged that although we have 2 year plan there is in year pressures that will take precedent over the initial agreed programme. We will ensure that when this does happen all submissions will be considered at CIG for change control and in line with the SFIs follow approval if required.</p>	Russell Caldicott, Executive Director of Finance	Capital prioritisation was submitted through CIG, execs and HB.
1541	Internal Audit	Discretionary Capital Funding Allocation	2025	Reasonable	Reasonable	Medium	<p>Objective 2: A risk-based approach is taken to review, scrutinise and prioritise bids for funding.</p>	<p>3. Business case approvals Our sample testing of approved business case documentation shows that some of them were lacking management and Finance approvals. Management advised that 'The business case template is under review. The process has changed in that we no longer require cases to be approved. The programme and supporting business cases are reviewed by each IHC's finance</p>	<p>3. It is agreed that the business case template is reviewed and aligned to demonstrate and demonstrate compliance with the current organisational committee structures.</p>	Russell Caldicott, Executive Director of Finance	All business cases are prioritised and approved through Divisional or IHC capital groups. Revenue implications are flagged. The 2-year discretionary programme is endorsed at CIG and approved through Execs, PFIG and Board. In addition the business case template being reviewed with the view to automate the process that will allow for transparency and improvement to approvals and reporting.
1552	Internal Audit	Waiting List Initiative payments – IHC Centre	2025	Limited	Limited	High	<p>Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.</p>	<p>2.1 WLI Payments We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.</p>	<p>Action 1. The procedure (above) and agreement of WLI sessions /claim forms to include confirmation that WLI activity complies with requirements of the Consultant Contract. This is a field that will be included in the new BCUHB electronic form to be used to monitor WLI compliance.</p>	Tehmeena Ajmal, Chief Operating Officer	Following the test period, the electronic form has now been updated with the additional questions to confirm that the WLI activity complies with the requirements of the national consultant contract in Wales and also whether the WLI activity will be undertaken in uncontracted time. These questions are mandatory on the online form that have to be completed before it can be submitted.
1555	Internal Audit	Waiting List Initiative payments – IHC Centre	2025	Limited	Limited	High	<p>Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.</p>	<p>2.4 WLI Payments We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.</p>	<p>Action 4. Whilst the procedure is under development, additional controls will be implemented to ensure agreed WLI activity is undertaken in uncontracted time noting the need for clarification from action 3. The new electronic form will capture confirmation that the activity is being performed in uncontracted time which will be audited by operational and medical leadership teams.</p>	Tehmeena Ajmal, Chief Operating Officer	Following the test period, the electronic form has now been updated with the additional questions to confirm that the WLI activity complies with the requirements of the national consultant contract in Wales and also whether the WLI activity will be undertaken in uncontracted time. These questions are mandatory on the online form that have to be completed before it can be submitted.

1557	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	Medium	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	<p>2. Assurance to Board / Committees</p> <p>We reviewed the agendas and minutes of all Board meetings and Planning, Population Health and Partnerships (PPHP) Committees held between January 2024 and March 2025 and found the following limitations:</p> <ul style="list-style-type: none"> • No assurance was provided regarding the progress / delivery of the PEC Strategy or Listening to Citizens Independent Review. • The PEC Strategy and Independent Review action plans have not been submitted to the Board or PPHP for review and scrutiny. 	<p>2. Strengthening Evidence and Impact Assurance for Improvement Actions</p> <p>To improve the consistency, transparency, and assurance of progress reporting, a revised approach will be adopted to strengthen the submission and verification of evidence for all improvement actions.</p> <p>This will include:</p> <ul style="list-style-type: none"> • Introduction of two new columns to the PEC Delivery Plan: <ul style="list-style-type: none"> o Benefits/Improvements – outlining the intended or actual change resulting from the action. o Evidence – detailing the supporting documentation or data required to verify delivery and impact. • Named leads for each action in the Delivery Plan will be responsible for collating appropriate evidence and submitting updates against this framework. • Quarterly internal assurance checks will be introduced to assess the quality and completeness of submitted evidence and to support ongoing audit readiness. <p>Target Implementation Date: The revised approach will be implemented in Q1 2025–26 (by end June 2025) and apply to all actions within the consolidated 2025–26 delivery plan.</p>	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Included in Consolidated plan
1559	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	<p>3.2 Staff resources</p> <p>We reviewed the evidence provided and found the following issues and limitations:</p> <ul style="list-style-type: none"> • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. 	<p>3.2 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.</p> <p>Key Deliverables:</p> <p>2. Review and update all published toolkits and guides on the Public Engagement Guides and Resources BetsiNet page:</p> <ul style="list-style-type: none"> • Update all materials dated 2021/2022 by July 2025. • Ensure all resources reflect current policy, best practice, and staff feedback. • Include version control, update dates, and named contact for each document. 	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Annual reviews in place. A SOP for the use of personal emails is no longer needed as the original finding related to two specific documents. One has been removed and the other references not using personal emails.
1560	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	<p>3.3 Staff resources</p> <p>We reviewed the evidence provided and found the following issues and limitations:</p> <ul style="list-style-type: none"> • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. 	<p>3.3 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.</p> <p>Key Deliverables:</p> <p>3. Ensure all toolkits and resources do not advise the use of personal emails</p>	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	The reference to personal emails was in the Padlet resource document (and a workforce document that is no longer on the resource page). The Padlet resource references not using personal emails. A SOP for the use of personal emails is no longer needed as the original finding related to two specific documents. One has been removed and the other references not using personal emails.

1562	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	3.5 Staff resources We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet.	3.5 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice. Key Deliverables: 5. Introduce a maintenance and review schedule: • Annual check and update of all engagement resources, with oversight by the Public Engagement and Communications Team. • Assign responsible owner(s) for each section or toolkit	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	A SOP for the use of personal emails is no longer needed as the original finding related to two specific documents. One has been removed and the other references not using personal emails.
1563	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	4. Operational oversight We did not receive meeting Terms of References, minutes, or agendas for several of the oversight forums referred to above. Where meeting minutes were provided, they did not demonstrate the extent of scrutiny, review of progress, or raising of issues for escalation.	4. Enhancing the Recording and Escalation of Progress and Issues Introduce a standardised and reliable approach to documenting progress updates and escalation of key issues across all relevant internal meeting types. This will include: 1. Ensure log of progress and escalation is used during: o One-to-one meetings between director and senior team leads o Team meetings o Bi-monthly senior leadership team (SLT) meetings 2. Ensure all significant updates and risks related to key programmes within the PEC Delivery Plan are: o Recorded clearly with context, actions taken, and any decisions made o Flagged for formal escalation where appropriate 3. Maintain a central repository (e.g. via SharePoint or Microsoft Teams) for securely storing and retrieving progress records and escalations, accessible to relevant leads and governance teams. 4. Review records quarterly to ensure completeness and identify recurring barriers or delivery challenges requiring escalation to senior governance forums.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Teams reflect discussions in notes and each SLT member follow up emails on discussions which reflect progress and escalation.
1564	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	5.1 Benefits Realisation There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements postimplementation. We noted the following limitations: • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review.	5.1 Integrate expected benefits and evidence of impact into routine delivery and monitoring. Key Deliverables: 1. Integrate benefits tracking into the PEC Delivery Plan, including: o Two new columns: "Expected Benefit/Improvement" and "Evidence of Impact" o Routine completion and updates by action owners as part of monitoring cycles Target Implementation Date: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025)	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Presented to Planning, Population Health & Partnerships Committee on 28/10/2025
1565	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	5.2 Benefits Realisation There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements postimplementation. We noted the following limitations: • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review.	5.2 Integrate expected benefits and evidence of impact into routine delivery and monitoring. Key Deliverables: 2. Implement quarterly benefits reviews, at the bimonthly senior leadership team meeting to assess progress against expected outcomes and ensure supporting evidence is being collected and analysed. Target Implementation Date: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025)	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Presented to Planning, Population Health & Partnerships Committee on 28/10/2025

1566	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	5.3 Benefits Realisation There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements postimplementation. We noted the following limitations: • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review.	5.3 Integrate expected benefits and evidence of impact into routine delivery and monitoring. Key Deliverables: 3. Report benefits realisation status bi-annually to the PPHP Committee Target Implementation Date: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025)	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Presented to Planning, Population Health & Partnerships Committee on 28/10/2025
1567	Internal Audit	Partnerships, Engagement and Communication	2025	Limited	Limited	High	Objective 4: There are robust governance arrangements in place to ensure that delivery of the Strategy, plan and recommendations from the independent report are subject to Health Board oversight and scrutiny, and assurance of progress is provided to the Board and / or relevant Committees.	6. Assurance to Board / Committees We reviewed the agendas and minutes of all Board meetings and Planning, Population Health and Partnerships (PPHP) Committees held between January 2024 and March 2025 and found the following limitations: • No assurance was provided regarding the progress / delivery of the PEC Strategy or Listening to Citizens Independent Review. • The PEC Strategy and Independent Review action plans have not been submitted to the Board or PPHP for review and scrutiny.	6. Establish a formal reporting and assurance process to ensure the PPHP Committee receives regular updates on progress, risks, and impact related to the PEC Delivery Plan 2025/26. Key Steps: 1. Biannual Highlight Reports – Provide biannual update papers to PPHP each November and March, including: o Current delivery position o Key achievements o Issues for escalation 2. Committee Scheduling – Work with Board Secretariat to agree a standing slot in the PPHP Committee annual workplan to ensure formal visibility and expectation of updates. 3. Strategic Oversight Role of PEC SLT – Ensure the PEC SLT has responsibility for reviewing assurance drafts prior to submission, enabling consistency and quality control.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	Presented to Planning, Population Health & Partnerships Committee on 28/10/2025
1588	Internal Audit	Grievance Management	2025	Reasonable	Limited	Medium	Objective 5: There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning.	3. Lessons learnt The All-Wales policy does not require lessons learnt to be captured, but suggests reflection and learning from the process. We recognise that outcomes and learning from cases is often discussed informally within meetings however it would be beneficial to capture that information and report via the Health Board governance structure to provide assurance that there is learning from grievance cases / actions taken to reduce likelihood of similar grievances being raised.	3. Lessons learned to be reviewed by Employment team / one to one's / Team locally. This will also go to the Executive Team for review and follow up, along with the information relating to delays for escalated cases.	Jason Brannan, Deputy Director of People	Regular reports are now in place to the People and Culture Committee private section. This notes themes and reasons for delays. All cases are recorded in ESR to allow for regular case tracking.
1590	Internal Audit	Budgetary Control 2025/26	2025	Reasonable	Reasonable	Medium	Objective 2: Accountability Letters have been completed and signed by all Budget Holders and Managers for 2024/25 in line with Standing Financial Instruction 5.2.1 and 5.2.6.	1. Accountability letters Not all staff have signed accountability letters including some senior management such as Directors. The letter is a formal acknowledgment of financial responsibility and not signing is against Standing Financial Instructions which says at 5.2.1: 'The budget holder must sign the accountability letter formally delegating the budget.' Whilst we recognise staff who have not signed letters are contacted, there is no further escalation / consequence for those staff who do not sign the letters – we note some of these are senior staff who are remunerated for the level of accountability.	1. Management will ensure staff sign accountability letters and non-compliance is escalated through the line management of individual staff. If managers wish to express a view that the budget they have been issued with is insufficient, they must raise this with a Finance Director and provide relevant details as to why this is the case. The Finance Director will deal with these issues on a case-by-case basis, and may need to refer to the Executive Director of Finance and/or the Chief Executive officer for further discussion and resolution. BCU has an ambition of 80% signoff of accountability agreements by the end of quarter 2, as stated in the special measure's response.	Russell Caldicott, Executive Director of Finance	As at 13/02/26 410 (95%) of accountability agreements have been signed off, of the remaining 23 to be signed, 7 are due to valid reasons (e.g. Long term sick, etc).

1608	Internal Audit	Waste Management - 2025	2025	Reasonable	Reasonable	Medium	Objective 5: Adequate arrangements are in place to record, monitor and report waste management activities.	5. Effective Communication of Spill and Environmental Emergency Procedures We were provided with a Spill and an Environmental Emergency procedure which describe steps to be followed in case of spillage and emergencies. We checked to establish if these procedures were made available to all staff through the Health Board intranet site. Management advised they currently have the procedures on a shared drive, and they are in the process of building a new Environmental Management web page which will enable them add/update documents including the Spill procedure and the Environmental Emergency procedures as well as other waste/environmental management information.	5. A target of 3 years refresher training has been agreed by the EMSG for Operational Estates Spill Response training. Emergency Procedure is available on the Environment & Waste webpage, and in all boiler rooms across the estate. Health & Safety are responsible for all other spill training and educational material/posters etc.	Stuart Keen, Director of Environment and Estates	Information contained on the 'Environment and Waste Management' BetsiNet page
1612	Internal Audit	Effective Governance – Integrated Health Community - East	2025	Limited	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	3. Delivering financial balance There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target	3. Review forecast year end position with finance team.	Tehmeena Ajmal, Chief Operating Officer	There are monthly CRES meetings with each Service to look at CRES and budget position, extraordinary meetings to discuss the extra CRES
1618	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1(a) - Action 2 - RECOMMENDATION: Staff should be reminded, through training, of the requirement to ensure the Falls and Bone Health Multifactorial Assessment (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. Current status - Partially implemented FINDING Training data provided by the Ward Accreditation Team shows an upward trend in falls training 1A and 1B over the past year. The Health Board's mandatory Falls Prevention E-learning module 1B, related to the FBHMA, has been updated. Additionally, a "how to" guide has been produced, featuring examples of effective risk assessments for FBHMA and patient handling forms. This guide offers extra clarity and expectations for Agency workers when operating within the Health Board. Progress has been made to enhance the quality of risk assessments through increased monitoring and coaching. This includes the following initiatives: • Embedding the process of monthly Ward Manager and Matron audit questions that	2.1(a) - Action 2 - The West Therapy Team has committed to the following action, with implementation complete by end Q2: The detail regarding the approach to improvement is in the process of being agreed by the Therapy leads. Changes to a patients' function can be documented in the WNCR which the ward would have access to. The leads will make staff aware of the FBHMA domains on the assessment form so they ensure assessment outcomes can be correctly communicated to the ward in the WNCR and board rounds in FBHMA terms.	Angela Wood, Executive Director of Nursing and Midwifery	Standing agenda item on the TL monthly meeting

1619	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	<p>2.1(b) RECOMMENDATION - To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.</p> <p>FINDING FOLLOWING FOLLOW-UP REVIEW: The Welsh Nursing Care Record (WNCR) digital system does not automatically populate patient details, such as mobility status, from the admission assessment section into the FBHMA. This issue affects all of Wales and the project to address it is expected to begin in approximately 18 months. In the meantime, the Health Board is mitigating the risk through control measures outlined in section 2.1a. A review of the questions within the FBHMA and the patient handling form is needed. Some questions, like "Is the patient at risk of falls?" seem repetitive. It may be beneficial to <u>merge the forms or reduce the repetition</u>.</p>	<p>2.1(b) All Wales Falls and Bone Health Multifactorial Assessment (FBHMA). WNCR Team to complete deep dive / audit of 30 patients to review completion and the quality of patient fall documentation –this will be done in July 2025 by the Chief Nursing Information Officer and reported back to the Strategic Falls group in September 2025 for action. Note: There are no formal plans on an All-Wales basis to update the national WNCR system. However, BCUHB will continue to request relevant information is auto populated on a future update.</p>	Angela Wood, Executive Director of Nursing and Midwifery	Deep Dive completed and presented to the Strategic Falls Group. Audit results shared with IHC Falls Leads for dissemination with teams.
1621	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.</p> <p>Current status – Partially implemented</p> <p>Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was considered, <u>the associated costs were</u></p>	<p>3.1(a) Action 1 - Training Manual Handling Mandatory Training compliance to be monitored by the Strategic Falls Group – this will be done at each meeting and any non-compliance escalated to the relevant services for action. (ongoing).</p>	Angela Wood, Executive Director of Nursing and Midwifery	Manual Handling Mandatory Training compliance to be monitored by the Strategic Falls Group. A report is produced by the Manual Handling Manager for the standing item on the agenda.
1625	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(c) Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.</p> <p>Current status – Partially implemented Finding Bedside learning has continued with the support of the Health Board's Health and Safety team, who review FBHMA documents on the ward. However, accurate records of the number of trained staff are still not maintained. Moving forward, the Falls Champions will take over this learning and will keep a record of the staff they train through bedside learning, as <u>this is a core part of their role and included in</u></p>	<p>3.1(c) Training Falls Champions to deliver bed side learning. Champions will record / log training. Training logs (monitored / reported via local Quality & Safety Groups and Accountability Meetings). Reported to Strategic Falls Group via IHC Divisional reporting slides – IHC Divisional Falls Leads (October 2025).</p>	Angela Wood, Executive Director of Nursing and Midwifery	Falls Champions have been identified across inpatient areas and have 4 hours protected time per month to undertake role. The Ward Accreditation team have developed a network and support framework for Falls Champions, including 1:1 support if required in ward environment. Falls Champion network sessions have included training session on Beside learning. The Strategic Falls meeting receive an update report from the Falls Leads for each IHC. This is now via a standardised template and is a standing agenda item. Evidence provided: standardised reporting template.

1626	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(d) 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.</p> <p>Current status – Partially implemented Finding Agency workers are encouraged to complete the E-learning module 1A (with access via the All-Wales learning platform. This is referenced in Section 10 of the Falls Policy. The Agency Onboarding Process commenced in September 2023, with the new checklist in place from October 2023. This involves verifying whether the agency staff have completed falls training (either the Health Board's eLearning module 1A training or an alternative falls training course). Although the Health Board encourages agency staff to complete the E-learning module 1A, and identifies if they have undergone alternative training, it remains challenging to ascertain whether agency staff have received training comparable to that provided to Health Board employees.</p>	<p>3.1(d) Training Temporary Staffing Team to complete monthly quality audits on 10% of agency workforce to ensure compliance with Falls 1a & 1b – Associate Director People Services, West (starting July 2025 then ongoing). Note: As of December 2024, it is Mandatory to complete the Falls Mandatory Training prior to onboarding / working in BCUHB. Prior to onboarding and throughout working at BCUHB, we have the assurance that all are accessing the same standard of training, and each worker receives proof of compliance in the form of a certificate with validity period dates on completing both Falls modules.</p>	Angela Wood, Executive Director of Nursing and Midwifery	<p>A full audit of Falls modules 1a and 1b for all agency workers was completed in August 2025 and showed just over 90% of these were fully compliant. Those found to be non-compliant have been given a week to bring themselves back to full compliance. Falls modules 1a and 1b will continue to be included in the mandatory training monthly audits of 10% of agency workers on an ongoing basis. An audit of modules Falls 1a and 1b conducted w/c 22-9-25 shows all agency workers are now compliant with the Falls 1a and 1b training. Moving forward compliance for Falls modules 1a and 1b will be audited as part of the full audit (of all training) of 10% of active agency workers from October on an ongoing basis. The evidence provided records the outcome of the audit that was carried out, with the date of birth and NI number redacted to meet GDPR requirements, leaving only the name as the least sensitive data.</p>
1627	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 4: Governance (Operation)	<p>4.1(a) Action 1: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.</p> <p>Current status - Partially implemented Finding In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this: <ul style="list-style-type: none"> • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify learning and immediate actions. • Rapid Review of complaints and incidents - we were provided with a document used by staff involved to identify immediate issues and </p>	<p>4.1(a) Action 1: Governance Chairs of local (IHC) Divisional Falls Learning Forums to ensure SWARM document completed locally as part of post falls review (monitored / reported via local Quality & Safety Groups and Accountability Meetings). Reported to Strategic Falls Group via IHC Divisional reporting slides – IHC Divisional Falls Leads (ongoing). Completion monitored via Matrons monthly metrics – Matrons (August 2025 and then after ongoing).</p>	Angela Wood, Executive Director of Nursing and Midwifery	<p>Falls Champion Network meetings for Sept/October across all the Health Board include SWARM document and rationale for using post fall. SWARM document part of the weekly review following a fall uploaded to datix incident reporting system. Matron Monthly metrics continue.</p>

1629	Internal Audit	Falls Management - Follow up	2025	N/A	Limited	High	Matter Arising 4: Governance (Operation)	<p>4.1(a) Action 3: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.</p> <p>Current status - Partially implemented Finding</p> <p>In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this:</p> <ul style="list-style-type: none"> • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify learning and immediate actions. • Rapid Review of complaints and incidents - we were provided with a document used by staff involved to identify immediate issues and 	<p>4.1(a) Action 3: Governance</p> <p>When Falls Champions established pan BCUHB, completion of SWARM will also be monitored / audited by Falls Champions (commenced April 2025, implementation December 2025).</p>	<p>Angela Wood, Executive Director of Nursing and Midwifery</p>	<p>Initial cohort of Falls Champions embedded with further Champions being recruited and established.</p> <p>IHC report template for the Strategic Falls Group incorporates feedback slides regarding the implementation and compliance with using the SWARM document.</p> <p>Best Practice guidance for weekly learning and improvement meeting for falls identifies SWARM as one of the key documents to be uploaded as part of Datix Incident reporting and to support decision making and outcome in terms of avoidable or unavoidable.</p> <p>Falls Champions have been recruited and are established. This will remain an ongoing action to continually review cohort of Champions and increase numbers with further recruits. Documentation has been introduced and is embedded with monitoring of compliance undertaken at various opportunities including; Strategic Falls Group, weekly learning and improvement meetings, Ward Manager monthly metrics and Matrons quality metrics as well as monitoring and support via Falls Champions.</p>
1648	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	Limited	High	Objective 4: Financial Management	<p>6. Project VAT calculations</p> <p>At BJC (January 2024), the recoverable VAT for the Project was estimated at £257,392, all attributable to fees, as assessed at the time. However, by July 2024, an additional £910,000 in potential VAT recovery was identified and reported contributing to a revised forecasted total cost of £27,034,255 against the approved budget of £27,944,695. This reduction in the forecast was attributed to an applied 9.88% abatement to the works element.</p> <p>This revised VAT figure, representing a potential saving of £910,000, was later reassessed by the VAT advisers and by February 2025, Cost Report No. 10 confirmed that this entire £910,000 VAT abatement on the Main Works had been re-evaluated and ultimately removed. There remains a lack of transparency and reporting for the significant changes in the VAT assumptions made to date.</p>	<p>6. The Standing orders, Scheme of Reservation and Delegation and Standing Orders will require for each major project professional recoverable VAT advice to be sought for the conclusion of each project decision gateway to validate any assumptions included within the cost plan. For instance, SOC, OBC, FBC and final account.</p> <p><i>Amendments to the Standing Financial Instructions, Scheme of Delegation and Standing Orders of the Health Board will be updated to require the Capital Accountant to agree through expert advice from the Health Boards VAT adviser will be sought to inform any to update the VAT position to be procured.</i></p>	<p>Russell Caldicott, Executive Director of Finance</p>	<p>The revised SFIs and SORD were approved by Board on 25 September 2025</p>
1676	Internal Audit	Digital Benefits and Change	2025	Reasonable	Reasonable	Medium	Objective 2: Benefits focussed digital business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined.	<p>1.1 Benefits Resource</p> <p>Our testing did note that resourcing for benefits leads was not always included within business cases, both from the DDaT and the service perspective.</p>	<p>1. Review of business case templates (SOC, OBC, FBC, Single Stage) to ensure that they include resources for benefits leads from the service and within the core project team where appropriate.</p>	<p>Dylan Roberts, Chief Digital and Information Officer</p>	<p>We have a standard single stage business case document (based on the treasury green book template), which considers benefits management resources in section 5.2.</p>

1677	Internal Audit	Digital Benefits and Change	2025	Reasonable	Reasonable	Medium	Objective 2: Benefits focussed digital business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined.	1.2 Benefits Resource Our testing did note that resourcing for benefits leads was not always included within business cases, both from the DDaT and the service perspective.	2. Review of the Gateway Review questions to ensure they include focus on the required benefits resources for each project phase (Feasibility, Start-Up, Initiation, Delivery, Closure, Post-Project).	Dylan Roberts, Chief Digital and Information Officer	Gateway Question database: will be reviewed for each digital project, via our Project for the Web system. The benefits questions relating to benefits (including planning for benefits resources) are highlighted in yellow
1678	Internal Audit	Digital Benefits and Change	2025	Reasonable	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.1 Benefits Reporting Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital projects.	2.1 Agree benefits reporting and escalation structure within the Digital Data and Technology (DDaT) Team.	Dylan Roberts, Chief Digital and Information Officer	Regarding the benefits reporting and escalation structure within DDaT, approved by DPDG, SBAR that was approved at DPDG and updated Benefits Framework.
1748	Internal Audit	Complaints management	2025	Reasonable	Limited	High	Objective 2: Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	2. Holding letters Our testing showed that holding letters are not always sent when complaint reviews exceed the 30-working-day regulatory timeline.	A weekly action list (every Monday) is now drawn from Datix identifying holding letters to be sent which will be undertaken by the corporate complaints team to remedy the issue immediately. On the rollout of the new Listening to People framework, the roll of sending out holding letters will be led by services, due to ownership of the complaint aligned to new processes.	Angela Wood, Executive Director of Nursing and Midwifery	Completed, process changed.

Open Unsatisfactory

Report title	Executive Lead	Open recs	Overdue recs	Overdue >6 Months	Open High Priority	Open High Priority Overdue	Open High Priority overdue >6 Months
Operating Model	Chief Executive	1	1	1	1	1	1
Consultant Job Planning	Executive Medical Director; Deputy Director of People	5	5	5	0	0	0
Waiting List Initiative payments – IHC Centre	Chief Operating Officer	1	1	1	1	1	1
Effective Governance - Cancer Services	Chief Operating Officer	1	1	1	1	1	0
Consultant Job Planning - Follow-up	Executive Medical Director	2	2	2	2	2	1
Nuclear Medicine Consolidation	Executive Director of Allied Health Professions and Health Science	3	1	1	2	0	0
	TOTAL	13	11	11	7	5	3

Open Limited recommendations

Report title	Executive Lead	Open recs		Overdue recs	Overdue >6 Months		High Priority	High Priority Overdue	High Priority overdue >6 Months
Health and Safety - 2024	Director of Environment and Estates	1		1	1		0	0	0
Corporate Legislative Compliance - Fire Safety	Director of Environment and Estates	2		2	2		1	1	1
Consultant Job Planning	Executive Medical Director; Deputy Director of People	1		1	1		0	0	0
Contracted Patient Services: Quality and Safety Arrangements - Follow-up	Executive Director of Finance	4		4	4		4	4	4
Effective Governance - Cancer Services	Chief Operating Officer	1		0			1	0	0
Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	Director of Corporate Governance	3		3	1		3	3	1
Falls Management - Follow up	Executive Director of Nursing and Midwifery	2		2	2		2	2	2
Performance Management Framework and Reporting	Executive Director of Finance	1		1	1		1	1	1
Digital Benefits and Change	Acting Director of Digital, Data and Technology	1		1	0		1	1	0
Learning – Regulatory Reporting	Director of Corporate Governance	5		2	0		5	2	0
Complaints management	Executive Director of Nursing and Midwifery	1		0	0		1	0	0
Contract management and procurement review – Corporate Directors	Executive Director of Finance	2		2	1		2	2	1
Estate Management – Estates and Facilities Alerts	Director of Environment and Estates	2		2	2		2	2	2
On-call arrangements	Chief Operating Officer	4		0	0		3	0	0
National Institute for Health and Care Excellence (NICE) guidance compliance	Executive Medical Director	4		3	0		2	1	0
Culture and Leadership Development – delivery of priorities	Executive Director of People Services and Organisational Development	1		1	1		1	1	1
Risk Management and Board Assurance Framework - 2026	Director of Corporate Governance	1		0	0		1	0	0
Speaking Up Safely	Executive Director of People Services and Organisational Development	4		0	0		4	0	0
Executive Committee: Governance	Director of Corporate Governance	4		4	0		4	4	0
Budget Setting	Executive Director of Finance	1		0	0		1	0	0

Standards of Business Conduct (2026)	Director of Corporate Governance	4	0	0	4	0	0
Non DDaT Controlled IT	Acting Director of Digital, Data and Technology; Chief Operating Officer; Executive Director of Allied Health Professions and Health Science	7	0	0	6	0	0
Pharmacy Regulatory Compliance	Executive Medical Director	7	7	7	7	0	0
Nuclear Medicine Consolidation	Executive Director of Allied Health Professions and Health Science	2	1	0	1	1	0
Challenged Services – Improvement plans	Interim Executive Director of Transformation and Strategic Planning	5	1	0	5	1	0
	TOTAL	70	38	23	62	26	13

Audit Wales – Open Recommendations by Executive/Report

Report Title	Executive Lead	Open recs	Overdue recs	Overdue >6 Months	Recs with no implementation date
Structured Assessment 2023	Executive Director of Finance	1	0	0	0
Review of Cost Savings Arrangements	Executive Director of Finance	2	0	0	0
Urgent and Emergency Care: Flow out of Hospital – North Wales Region	Chief Operating Officer	5	0	0	0
Tackling the Planned Care Challenges	Chief Operating Officer	22	0	0	22
Structured Assessment 2025	Director of Corporate Governance	4	0	0	0
Review of Quality Governance	Executive Medical Director; Executive Director of Nursing and Midwifery; Executive Director of Allied Health Professions and Health Science	9	1	0	0
Digital Transformation	Acting Director of Digital, Data and Technology	11	0	0	0
	TOTAL	54	1	0	22



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Ymchwiliad i gŵyn
yn erbyn
Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Adroddiad gan
Ombwdsmon Gwasanaethau Cyhoeddus
Cymru
Achos: 202501841

Cynnwys	Tudalen
Cyflwyniad	1
Crynodeb	2
Y gŵyn	5
Ymchwiliad	5
Safonau a chanllawiau perthnasol	5
Y digwyddiadau cefndir	8
Tystiolaeth Mrs P	11
Tystiolaeth y Bwrdd Iechyd	12
Cyngor proffesiynol	14
Dadansoddiad a chasgliadau	23
Argymhellion	30

Cyflwyniad

Cyhoeddir yr adroddiad hwn o dan adran 23 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019.

Rydym wedi cymryd camau i ddiogelu hunaniaeth yr achwynydd ac eraill, cyn belled â phosib. Mae enw'r achwynydd ac eraill wedi'u newid hefyd.

Crynodeb

Cwynodd Mrs P am y gofal a ddarparwyd gan y Bwrdd Iechyd i'w diweddar wr, Mr P, yn Ysbyty Maelor Wrecsam ym mis Mawrth 2024. Bu'r ymchwiliad yn ystyried a oedd yn glinigol briodol i ragnodi Sevredol (morffin sylffad) i Mr P ac a oedd Mr P a'i deulu wedi cael digon o wybodaeth a chymorth i leihau'r risgiau diogelwch sy'n gysylltiedig â rhagnodi Sevredol.

Cadarnhawyd y ddwy gŵyn. Canfu'r ymchwiliad fod morffin sylffad wedi'i roi ar gam i Mr P pan adawodd yr ysbyty. Roedd y meddyg rhagnodi wedi rhagnodi'r feddyginiaeth at ddefnydd yn yr ysbyty'n unig a gwnaeth hynny gan gredu, yn anghywir, bod Mr P wedi bod yn cymryd y feddyginiaeth cyn cael ei dderbyn i'r ysbyty. Bu cyfres o fethiannau i gynnal y gwiriadau disgwyledig a fyddai wedi canfod y camgymeriad hwn. Cafodd hyn ei waethygu o ganlyniad i gyfathrebu gwael rhwng y timau meddygol a fferyllol. Y canlyniad oedd bod Mr P wedi cael meddyginiaeth a reolir heb iddo fod yn ymwybodol o'r risgiau a heb arweiniad ar sut i'w chymryd yn ddiogel.

Yn anffodus, bu farw Mr P o ganlyniad i orddos o forffin 2 ddiwrnod yn ddiweddarach. Canfu'r ymchwiliad fod cyflenwi morffin sylffad i Mr P mewn camgymeriad a heb gyngor ac arweiniad priodol wedi cynyddu'n sylweddol y risg y byddai'n cymryd gorddos damweiniol. Roedd hyn yn anghyfiawnder difrifol dros ben i Mr P a'i deulu.

Roedd yr Ombwdsmon yn bryderus hefyd fod y Bwrdd Iechyd wedi colli cyfleoedd i gydnabod ac i roi sylw i ddifrifoldeb y methiannau cyfathrebu a phroses a arweiniodd at y camgymeriad rhagnodi. Nid oedd hyn yn cyd-fynd â rhwymedigaethau'r Bwrdd Iechyd o dan y Ddyletswydd Gonestrwydd sy'n rhoi gofyniad ar sefydliadau GIG Cymru i fod yn agored â defnyddwyr gwasanaeth pan fydd pethau'n mynd o chwith.

Nododd yr Ombwdsmon mai hwn oedd yr ail adroddiad budd y cyhoedd yn olynol a gyhoeddwyd ganddi'n ymwneud â'r Bwrdd Iechyd a oedd wedi canfod diffygion o ran y Ddyletswydd Gonestrwydd. Dywedodd yr Ombwdsmon y byddai'n disgwyl i'r Bwrdd Iechyd fanteisio ar y cyfle hwn i sicrhau bod gofynion ac ysbryd y Ddyletswydd Gonestrwydd yn cael eu hymgorffori'n llawn yn niwylliant ac arferion gweithio pob dydd ei dimau clinigol a chwynion.

Cytunodd y Bwrdd Iechyd i weithredu ar argymhellion yr Ombwdsmon i:

- a) Ymddiheuro i Mrs P am y methiannau a nodwyd yn yr adroddiad hwn, ac yn benodol, am ragnodi Sevredol i Mr P heb sicrhau ei fod yn ddiogel ac am fethu rhoi cyngor priodol iddo ar y risgiau a oedd ynghlwm wrth ei ddefnyddio.
- b) Talu iawndal o £2000 i Mrs P i adlewyrchu'r anghyfiawnderau a achoswyd i Mr P a'i deulu gan y methiannau hyn.
- c) Rhannu'r pwyntiau dysgu o'r achos hwn (mewn ffurf sy'n gwbl ddiennw) â'r holl staff meddygol a fferyllol a'u hatgoffa o'u cyfrifoldebau'n unol â chanllaw cyffuriau a reolir NICE, a Pholisi Meddyginiaethau'r Bwrdd Iechyd. Dylai'r cyfathrebu hwn bwysleisio pwysigrwydd dogfennu'r rheswm clinigol dros ragnodi, a phwysleisio y dylai rhagnodi meddyginiaethau'n ddiogel fod yn flaenoriaeth, ac y dylai clinigwyr ystyried oedi cyn rhyddhau cleifion neu beidio â chyflenwi meddyginiaethau os oes angen er mwyn cyflawni hyn. Dylai hefyd bwysu arnynt i wneud pob ymdrech i gynghori cleifion am eu meddyginiaethau cyn eu rhyddhau, gyda blaenoriaeth i'r cleifion hynny ar feddyginiaethau risg uchel fel opioidau a gwrthgeulyddion a rhai y rhagnodir meddyginiaethau newydd iddynt.
- d) Rhannu'r adroddiad hwn â'r Ymgynghorydd er mwyn myfyrio fel rhan o ddatblygiad proffesiynol parhaus ac i'w ystyried yn eu harfarniad blynyddol nesaf.
- e) Rhannu'r adroddiad hwn â thîm ymchwilio i gwynion y Bwrdd Iechyd i adolygu sut y cynhaliwyd ei ymchwiliad yn unol â'r Ddyletswydd Gonestrwydd ac i nodi pwyntiau dysgu i sicrhau nad yw methiannau tebyg yn cael eu methu yn y dyfodol. Dylai unrhyw welliannau a amlygir gael eu hymgorffori yn ei weithdrefn delio â chwynion a'u rhannu â fy swyddfa.
- f) Rhannu'r adroddiad hwn â Phwyllgorau Ansawdd a Diogelwch Cleifion ac Ansawdd a Risg y Bwrdd Iechyd i ystyried fy nghanfyddiadau a chynnwys yr hyn a ddysgwyd yn sgil yr argymhellion hyn yn ei adroddiad Dyletswydd Gonestrwydd Blynyddol.

g) Cynnal adolygiad o brosesau ac arferion gweithio o fewn y timau meddygol a fferyllol i roi sylw i'r holl fethiannau a nodwyd yn yr adroddiad hwn. Dylai'r adolygiad gael ei gydlynu drwy gynnwys uwch reolwyr a'r cyfarwyddwyr meddygol o fewn y cyfarwyddiaethau perthnasol. Dylai:

- Ymchwilio a sicrhau bod pob presgripsiwn yn cael eu gwirio'n briodol a bod ymholiadau gan y rhagnodydd a'r fferylllydd ar y ward (gweler paragraff 43), a phan nad yw hyn yn bosibl bod yr un camau'n cael eu dilyn gan fferylllydd cyn rhyddhau'r claf.
- Nodi camau i wella gweithio amlbroffesiwn a chyfathrebu rhwng timau meddygol a fferyllol.
- Ystyried a ddylai'r broses i gwblhau crynodeb rhyddhau interim gael ei newid i gynnwys gwybodaeth i nodi a oedd y presgripsiwn yn newydd, ynteu wedi'i gyhoeddi cyn derbyn y claf i'r ysbyty.
- Canfod a rhoi sylw i rwystrau sy'n atal clinigwyr rhag cael mynediad at wybodaeth am bresgripsiynau gan bractisau meddygon teulu yn Lloegr.
- Ystyried a yw DMR yn cael eu defnyddio pan yn briodol, a mynd i'r afael ag unrhyw rwystrau rhag eu defnyddio yn achos cleifion trawsffiniol.

Fel rhan o'r adolygiad, dylai'r Bwrdd lechyd gynnal archwiliad o sampl a ddewiswyd ar hap o gleifion a ryddhawyd o'r AMU yn y 6 mis diwethaf i ganfod a oedd y presgripsiynau a ddarparwyd ar adeg rhyddhau wedi bod yn destun gwiriadau priodol yn unol â safonau mewnol ac allanol perthnasol. Dylai'r Bwrdd lechyd gyflwyno canlyniad yr adolygiad a'r archwiliad i'r Ombwdsmon ynghyd â chynllun gweithredu i roi sylw i unrhyw achosion o ddiffyg cydymffurfiaeth a ganfuwyd yn ystod yr archwiliad.

Y gŵyn

1. Cwynodd Mrs P am y gofal a ddarparwyd gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr (“y Bwrdd Iechyd”) i’w diweddar wr, Mr P, yn Ysbyty Maelor Wrecsam (“yr Ysbyty”) ym mis Mawrth 2024. Bu’r ymchwiliad yn ystyried a oedd:

- yn glinigol briodol i ragnodi Sevredol (morffin sylffad) i Mr P
- Mr P a’i deulu wedi cael digon o wybodaeth a chymorth i leihau’r risgiau diogelwch sy’n gysylltiedig â rhagnodi Sevredol.

Yr ymchwiliad

2. Cafodd fy archwilydd sylwadau a chopïau o ddogfennau perthnasol gan y Bwrdd Iechyd a bu’n ystyried y rhain ynghyd â’r dystiolaeth a gafwyd gan Mrs P. Cafwyd cyngor proffesiynol hefyd gan 2 gynghorydd proffesiynol, Dr Salim Cheeroth, ymgynghorydd mewn meddygaeth aciwt a geriatrig (“y Cynghorydd Ymarfer Cyffredinol”) a Ms Dianne Burnett, fferylllydd clinigol (“y Cynghorydd Fferyllol”).

3. Cafodd Mrs P a’r Bwrdd Iechyd gyfle i weld a chynnig sylwadau ar ddrafft o’r adroddiad hwn cyn cyhoeddi’r fersiwn derfynol.

Safonau a chanllawiau perthnasol

4. Bu’r ymchwiliad yn ystyried y canllawiau canlynol a gyhoeddwyd gan y Cyngor Meddygol Cyffredinol (“y GMC”):

- “Good practice in proposing, prescribing, providing and managing medicines and devices” y GMC, a ddiwygiwyd ddiwethaf ym mis Mawrth 2022 (“Canllaw Presgripsiynau’r GMC”). Ym mharagraff 26 dywedir na ddylai clinigwyr ragnodi meddyginiaethau os nad oes ganddynt wybodaeth ddigonol am iechyd y claf. Dywed hefyd fod yn rhaid i glinigwyr ystyried a yw’r wybodaeth sydd ganddynt yn ddigonol ac yn ddigon dibynadwy i’w galluogi i ddarparu gofal diogel. Dylent ystyried a oes ganddynt fynediad at gofnodion meddygol y claf neu wybodaeth ddibynadwy arall am eu hiechyd a thriniaethau

eraill maent yn eu cael. Gan gyfeirio at ragnodi meddyginiaethau a reolir, dywedir ym mharagraff 59: “If you don’t have access to relevant information from the patient’s medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important”.

- “Good Medical Practice”, y GMC 2024 (“Canllaw Ymarfer da y GMC”) (paragraffau 69-71), “Recording your work clearly, accurately, and legibly”. Mae hwn yn disgrifio’r gofynion ar gyfer cofnodi eglur a chywir ac mae’n cynnwys arweiniad ar lefel y manylder a ddylai gael ei gynnwys yng nghofnodion cleifion.

5. Bu’r ymchwiliad yn ystyried y canllawiau canlynol a gyhoeddwyd gan y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE):

- Canllaw Clinigol CG150 NICE “Headaches in over 12s: diagnosis and management”, 2012 (“Canllaw NICE ar Gur Pen”).
- “Clinical Knowledge Summary for Migraine” NICE (“CKS NICE ar Feigryn”), a ddiwygiwyd ddiwethaf fis Awst 2025.
- Canllaw Cenedlaethol NG46 NICE “Controlled drugs: safe use and management”, 2016 (“Canllaw NICE ar gyffuriau a reolir”).
- Canllaw Clinigol NG215 NICE “Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults” (“Canllaw NICE ar feddyginiaethau sy’n achosi dibyniaeth”).

6. Bu'r ymchwiliad hefyd yn ystyried:

- Canllaw Llyfr Fformiwlâu Cenedlaethol Prydain ("y BNF") ar gyfer morffin ("Canllaw Morffin y BNF"). Mae hwn yn cynghori clinigwyr i "counsel patients and their carers on the risks of tolerance and potentially fatal unintentional overdose, as well as signs and symptoms of overdose".
- Polisi Meddyginiaethau'r Bwrdd Iechyd' (2019, fersiwn 2.12). Dywed hwn: "mae rhagnodwyr yn gyfrifol am fonitro a sicrhau bod y meddyginiaethau a ragnodwyd ganddynt wedi cael eu hadolygu. Dylai rhagnodwyr gyfeirio at bresgripsiynau presennol/siartiau atodol a chofnodion y claf sydd ar gael (e.e. Cofnod Iechyd Unigol - sy'n cynnwys manylion am y Practis Meddyg Teulu a meddyginiaethau cyfredol - a chofnodion gofal eilaidd) cyn rhagnodi neu newid presgripsiwn...Dylai'r rhagnodydd gynghori'r claf ar sgil effeithiau pwysig a rhagofalon, gan gynnwys unrhyw angen am fonitro parhaus, ac os bydd angen hynny cytunir ar hynny rhwng y clinigwyr gofal sylfaenol ac eilaidd." Dywed hefyd y dylai fferyllwydd wirio'n glinigol bob presgripsiwn rhyddhau i sicrhau eu bod yn ddiogel a phriodol.
- Canllawiau Rheoli Poen Ffarmacoleg Cymru Gyfan (2023).
- Polisi Cysoni Meddyginiaethau Amlddisgyblaethol Cymru Gyfan (ymddeolwyd yn 2025).
- Safonau ar gyfer gweithwyr fferyllol proffesiynol" y Cyngor Fferyllol Cyffredinol "May 2017 ("Safonau'r GPhC"). Mae'r rhain yn gymwys i dechnegwyr fferyllfa a fferyllwyr ac yn gymwys ym mha bynnag leoliad mae claf yn cael gofal.

7. Cyflwynwyd Dyletswydd Gonestrwydd GIC Cymru yng Nghymru ar 1 Ebrill 2023. Y brif egwyddor (a geir yng Nghanllaw cysylltiedig Llywodraeth Cymru) yw "bod yn agored â defnyddwyr gwasanaeth a'u cynrychiolwyr pan fydd pethau'n mynd o chwith yw'r peth iawn i'w wneud". Mae hyn yn ychwanegol at unrhyw ddyletswydd gonestrwydd proffesiynol y bydd gweithiwr gofal iechyd proffesiynol yn ddarostyngedig iddynt o dan

drefniadau eu hymarfer proffesiynol eu hunain ac mae'n gymwys yn benodol pan fydd darparwr gofal iechyd yn ymateb i gwynion am wasanaeth.

8. Fy adroddiad thematig, "Rhoi Diwedd ar yr un Hen Gân Beunyddiol: Cyfle i newid y ffordd rydym yn delio â chwynion?", Mehefin 2023 ("yr Adroddiad Thematig"). Roedd yr adroddiad yn cynnwys achosion lle nad oedd tystiolaeth amlwg o fethiant gwasanaeth wedi cael sylw gan gyrrff cyhoeddus yn ystod ymchwiliadau i gwynion, sy'n dangos nad oeddent yn ymddwyn mewn ffordd agored a gonest. Roedd hefyd yn dangos diffygion cyson wrth adolygu gofal clinigol a thriniaeth yn wrthrychol. Nodwyd mai'n anaml iawn mae cyrff y GIG yn cael cyngor meddygol annibynnol i gynorthwyo mewn ymchwiliadau i gwynion. Mae'r opsiwn hwn ar gael iddynt o dan weithdrefn gwyno'r GIG.

Y digwyddiadau cefndir

9. Cafodd Mr P strôc yn **2022**. Yn dilyn hynny cafodd ei ddiswyddo o'i swydd ac aeth ymlaen i brofi gorbryder ac iselder. Hefyd, datblygodd ludedd ôl-strôc a chur pen cronig (cafodd ei weld cyn hyn gan ei feddyg teulu am feigryn yn 2010).

10. Ar 16 Chwefror **2024** cafodd Mr P ei dderbyn i'r Ysbyty gyda symptomau a oedd yn cynnwys gorbryder, chwysu a rhithweledigaethau. Nodwyd ei fod wedi rhoi'r gorau i yfed yn sydyn 4 diwrnod cyn hynny ar ôl cyfnod o 2-3 mis o yfed tua hanner potel o fodca'r dydd yn y dirgel. Cafodd ddiagnosis o ddiddyfniad alcohol a'i drin â meddyginiaethau dadwenwyno cyn ei ryddhau ar 23 Chwefror.

11. Ar 5 Mawrth, aeth Mrs P â Mr P i'r adran frys yn yr Ysbyty. Roedd yn profi rhithweledigaethau a dryswch a oedd yn gysylltiedig â'i symptomau diddyfnu oddi ar alcohol. Ar adeg ei dderbyn bu'r tîm fferyllol yn cysoni meddyginiaethau cyfredol Mr P (lle mae cyfundrefn feddyginiaethau'r claf yn cael ei hadolygu a'i gwirio i sicrhau bod gan glinigwyr restr gywir o'u meddyginiaethau cyfredol ac i ganfod unrhyw anghysondebau). Fel rhan o'r broses hon cysylltodd aelod o'r tîm fferyllol â phractis meddyg teulu Mr P yn Lloegr.

12. Cadarnhaodd y cysoni meddyginiaethau fod Mr P ar adeg ei dderbyn ar 5 Mawrth yn cymryd y meddyginiaethau canlynol: warfarin, omeprazole, atorvastatin, propranolol a sertraline. Nodwyd fod presgripsiwn o thiamin wedi'i wneud yn yr Ysbyty, a bod Mr P wedi bod yn prynu paracetamol dros y cownter. Nid oedd cyfeiriad at Sevredol nac unrhyw feddyginiaeth opiad fel Zomorph (morffin sylffad ar ffurf capsïwl). (Nid oedd cofnodion meddyg teulu Mr P a oedd yn dyddio'n ôl i fis Mawrth 2021 yn cynnwys cyfeiriadau at ragnodi meddyginiaethau opiad iddo).

13. Ar adeg ei dderbyn, cafodd Mr P ei weld gan nyrsys cyswllt alcohol ("ALNs") a chafodd ragor o feddyginiaethau dadwenwyno. Ar 7 Mawrth cafodd Mr P ei drosglwyddo i ward Arhosiad Byr yr Uned Meddygaeth Acíwt ("yr AMU") lle'r oedd dan ofal arenegwr ymgynghorol (meddyg sy'n arbenigo yng nghlefydau'r arennau a chyflyrau cysylltiedig - "yr Ymgynghorydd"). Ar 9 Mawrth cofnododd nyrs fod Mr P wedi cwyno bod ganddo gur pen a'i fod wedi cael paracetamol a gafodd "effaith gymedrol". Y diwrnod canlynol cofnodwyd fod Mr P yn dal i gwyno am gur pen a chyfog ers iddo gael ei dderbyn.

14. Ar 13 Mawrth cafodd Mr P ei adolygu gan ALN. Nodwyd ei fod wedi cwblhau'r drefn ddiddychu oddi ar alcohol a'i fod yn teimlo'n dda ac ni chafodd problemau eu nodi. Cafodd ei ryddhau gan y gwasanaeth cyswllt alcohol. Cafodd Mr P ei weld hefyd gan yr Ymgynghorydd a ddywedodd mai'r nod oedd ei ryddhau'r diwrnod canlynol, yn dilyn adolygiadau gan y timau seiciatreg a ffisiotherapi. Cynhaliwyd adolygiad ffisiotherapi'n ddiweddarach y diwrnod hwnnw.

15. Tua 10:15 ar 14 Mawrth gwelodd yr Ymgynghorydd Mr P ar rownd ward. Nododd fod Mr P yn aros am adolygiad gan y tîm cyswllt seiciatreg gyda golwg ar ei ryddhau'n ddiweddarach y diwrnod hwnnw.

16. Yn dilyn y rownd ward cafodd presgripsiwn am forffin sylffad ei ychwanegu at siart meddyginiaethau Mr P. Cafodd "meigrin" ei gofnodi ar y siart fel y rheswm clinigol a'r dos oedd 10mg bob 4 awr PRN (pro re nata – yn ôl yr angen). Mae'r siart yn dangos na chafodd dim dosau eu gweinyddu. Nid yw'r cofnodion clinigol yn cynnwys cyfeiriad arall at y rhesymau clinigol dros y presgripsiwn hwn.

17. Cysylltodd Mr P â'i feddyg teulu i ofyn am feddyginiaeth i'w helpu i gysgu yn yr ysbyty. Dywedodd cynrychiolydd o bractis y meddyg teulu na allai roi meddyginiaeth iddo tra'r oedd yn glaf mewnol yn yr Ysbyty.

18. Am 17:00 nododd y nyrs cyswllt seiciatreg ei bod yn ymddangos fod Mr yn ymgodymu â galar o'r gorffennol, ond nad oedd wedi nodi problemau â'i hwyliau na synio am hunanladdiad ac nad oedd tystiolaeth o unrhyw salwch meddwl arwyddocaol. Nodwyd fod gan Mr P apwyntiad am gwnsela preifat ar 18 Mawrth yr oedd ef ei hun wedi'i drefnu. Cafodd Mr P ei ryddhau adref yn hwyrach y noson honno. Roedd y rhestr o feddyginiaethau ar yr hysbysiad rhyddhau'n cynnwys presgripsiwn am Sevredol (10 tabled 10mg i'w cymryd pan oedd angen). Cafodd y feddyginiaeth ei chofnodi fel cyffur cyn derbyn a fyddai'n parhau.

19. Ar 16 Mawrth canfuwyd Mr P yn anymwybodol yn ei gartref. Ffoniodd Mrs P 999 a dywedodd ei bod yn poeni bod Mr P wedi cymryd gorddos o forffin ar ddamwain. Cyrhaeddodd parafeddygon am 06:03 ac ymdrechwyd i roi adfywiad cardiopwlmonaidd iddo, ond yn anffodus cyhoeddwyd fod Mr P wedi marw'n fuan wedyn. Nododd y parafeddygon nad oedd tystiolaeth o feddyginiaethau na pheccynau gwag yn agos ato.

20. Dywedodd adroddiad post mortem fod dadansoddiad tocsicoleg wedi canfod lefelau morffin yng ngwaed Mr P a fyddai, mewn rhywun na allai oddef morffin, yn cyfrif fel lefelau tocsig angheuol (roedd gan Mr P 160 ng/mL o forffin yn ei waed – gall unrhyw lefel dros 50ng/mL fod yn angheuol). Nodwyd nad oedd dim tystiolaeth fod hunanladdiad wedi'i gynllunio. Nodwyd hefyd ei fod wedi cymryd Zomorph cyn hynny, ond nid oedd yn amlwg o ble daeth yr wybodaeth hon ac ni chafwyd rhagor o fanylion.

21. Ym mis Gorffennaf cofnododd cwest y crwner ganfyddiad o farwolaeth drwy anffawd.

22. Ar 8 Medi, cyflwynodd Mrs P gŵyn ffurfiol i'r Bwrdd Iechyd. Ar 20 Medi, cynhaliodd y Bwrdd Iechyd Adolygiad Cyflym ("yr Adolygiad Cyflym" - cyfarfod a drefnir ar ôl i bryder gael ei fynegi sy'n cynnwys marwolaeth claf). Yn bresennol yn yr Adolygiad Cyflym roedd y swyddog ymchwilio, y Cyfarwyddwr Clinigol dros Feddygaeth a'r Gymuned, y Fetron ar gyfer Gofal Argyfwng, Fferylllydd Arweiniol Diogelwch Cleifion a Hwylusydd Llywodraethiant Clinigol.

Tystiolaeth Mrs P

23. Ar ôl i'w gŵr ddioddef strôc, dywedodd Mrs P ei fod wedi cael trafferth mawr wrth geisio rheoli ei iechyd. Dywedodd ei fod wedi dioddef lludded ôl strôc ac wedi gorfod ymgodymu â salwch ac o ran bwyta. Cafodd ddiagnosis o gyflwr ar y gwaed a oedd yn gofyn am feddyginiaeth ddyddiol i deneuo'r gwaed a datblygodd wlserau yn y stumog, gorbryder ac iselder. Dywedodd fod ei gyflyrau wedi gwaethygu, gydag un yn achosi un arall, gyda symptomau'n gorgyffwrdd, ac un salwch yn gallu cuddio un arall; cafodd nifer o archwiliadau gan sawl ymgynghorydd a nifer o apwyntiadau â'i feddyg teulu ac yn yr ysbyty. Dywedodd fod y cylch diddiwedd hwn wedi achosi cryn rwystredigaeth iddo.

24. Dywedodd Mrs P fod Mr P, yn anffodus, wedi troi at alcohol a meddyginiaethau'n dawel bach mewn ymdrech i ymdopi ag effeithiau llethol ei salwch. Roedd yr ymddygiadau hyn wedi'u cuddio y tu ôl i gymhlethdod ei gyflyrau eraill ac nid oedd hi na'r gweithwyr meddygol proffesiynol a oedd yn gofalu amdano wedi sylwi arnynt.

25. Dywedodd Mrs P ei bod yn gobeithio ei fod mewn amgylchedd diogel, lle'r oedd yn cael gofal priodol gan weithwyr proffesiynol a oedd yn ymwybodol o'i hanes meddygol, ei wendidau, a'r risgiau yr oedd yn eu hwynebu, ond nid oedd sail i'r ffydd hwnnw. Dywedodd nad oedd yn gwybod bod Sevredol wedi'i ragnodi i Mr P pan gafodd ei ryddhau o'r Ysbyty. Dywedodd nad oedd Mr P wedi cael copi o'r crynodeb rhyddhau ar adeg ei ryddhau, ac nad oedd wedi sôn wrthi am y feddyginiaeth morffin.

26. Dywedodd Mrs P na allai ddeall sut y gallai'r Ymgynghorydd fod wedi rhagnodi'r feddyginiaeth a hynny am fod Mr P wedi gofyn amdani, heb wirio a oedd yr hyn roedd yn ei ddweud yn ddibynadwy. Gofynnodd a oedd yn briodol i ragnodi'r cyffur o gofio hanes Mr P o gaethiwed i alcohol, ac o ddryswch a rhithweledigaethau. Dywedodd ei bod yn bosibl y gallai ei gur pen fod wedi'i achosi gan ddiddyfniad, ac y dylai meddyginiaethau eraill a oedd yn llai o risg fod wedi'u rhagnodi iddo. Dywedodd ei bod yn teimlo ei bod wedi ei gadael i lawr gan yr union weithwyr proffesiynol hynny y dylai fod wedi ymddiried ynddynt: y rhai roedd ei gŵr yn ymddiried ac yn dibynnu arnynt am help.

27. Dywedodd Mrs P nad oedd problemau caethiwed ei gŵr wedi cael y sylw roeddent yn eu haeddu. Ar ôl iddo gael ei drin am ddiddymiad roedd yn teimlo ei fod yn chwilio am rywbeth i gymryd lle'r alcohol, a dyna pam yr oedd wedi gofyn i'r Ymgynghorydd am forffin. Dywedodd ei fod wedi gofyn i'w feddyg teulu am feddyginiaeth ond yr oedd wedi gwrthod.

28. Dywedodd Mrs P nad oedd Mr P wedi cael unrhyw arweiniad ar sut i gymryd morffin sylffad yn ddiogel. Dywedodd ei bod yn teimlo bod ei gŵr wedi cael ei anfon adref o'r ysbyty gyda gwn wedi'i lwytho.

29. Dywedodd Mrs P ei bod wedi canfod Mr P gyda phegyn gwag o Zomorph ar fore 15 Mawrth, a oedd yn hen bresgripsiwn allan o ddyddiad a roddwyd i'w thad ac nad oedd wedi sylweddoli ei fod yn ei feddiant. Dywedodd mai'r unig adeg arall pan gafodd morffin ei ragnodi i Mr P oedd ar ôl iddo anafu ei droed yn 2006. Dywedodd pan aeth Mr P i'w wely'r noson honno nid oedd yn gwybod pa feddyginiaethau roedd wedi'u cymryd. Dywedodd ei bod yn ymateb yn iawn ac nad oedd yn sylweddoli ei fod mewn unrhyw berygl.

Tystiolaeth y Bwrdd Iechyd

30. Dywedodd y Bwrdd Iechyd mewn ymateb i'r ymchwiliad fod yr Ymgynghorydd wedi rhagnodi dos cymharol fychan o Sevredol i Mr P, ar gyfer defnydd cleifion mewnol yn bennaf, a hynny am fod Mr P wedi dweud ei fod yn ei gymryd at ei gur pen. Dywedodd, am y rheswm hwnnw, roedd y presgripsiwn yn glinigol briodol. Dywedodd nad oedd Mr P wedi gofyn am gael mynd â'r feddyginiaeth adref, a phe bai Mr P wedi gofyn am hynny, y byddai'r Ymgynghorydd wedi ei gwestiynu.

31. Dywedodd y Bwrdd Iechyd ei fod yn ymddangos ar daflen nodiadau wedi'i hysgrifennu â llaw a gwblhawyd ar 8 Mawrth fod y tîm fferyllol wedi cadarnhau meddyginiaeth reolaidd Mr P â'r meddyg teulu yn Lloegr drwy e-bost. Dywedodd fod y ddogfennaeth hon yn dangos nad oedd Sevredol nac unrhyw baratoad morffin arall wedi cael ei ragnodi i Mr P o'r blaen gan ei feddyg teulu ac nad oedd y meddyg a'i derbyniodd wedi'i ragnodi iddo. Dywedwyd nad oedd y ddalen nodiadau wedi'i hargraffu ac wedi'i rhoi ar ffeil am ei bod yn cadarnhau hanes cyffuriau a oedd wedi'i ddogfennu eisoes. Dywedwyd fod meddyg preswyl yn nhîm yr Ymgynghorydd wedi paratoi presgripsiynau

rhyddhau Mr P gyda 10 tabled 10mg o Sevredol i fynd adref a nodwyd fod hwn yn gyffur cyn-derbyn a hynny ar sail yr wybodaeth a roddwyd gan Mr P.

32. Dywedodd y Bwrdd Iechyd fod y daflen rhyddhau interim a ddarparwyd gan dîm yr Ymgynghorydd i'r tîm fferyllol yn daflen safonol nad oedd yn cynnwys adran ar ddosbarthu meddyginiaethau fel "parhau â chyffur cyn derbyn" neu "wedi'i roi yn yr ysbyty". Dywedodd fod hyn yn cyd-fynd ag arferion gweithio safonol i wella'r amser a gymer i baratoi meddyginiaethau'n barod ar gyfer rhyddhau cleifion ac i alluogi'r meddyg i baratoi'r llythyr rhyddhau pan fydd amser yn caniatáu. Dywedwyd fod y llythyr rhyddhau wedi'i baratoi ar 18 Mawrth felly ni fyddai'n debygol o fod yn eglur i'r fferylllydd a oedd y paratoad newydd ei ragnodi ynteu a oedd yn ailddechrau. Fodd bynnag, nid oedd yn rhaid cael yr wybodaeth hon i farnu a oedd y presgripsiwn yn glinigol briodol. Dywedwyd yn ystod yr Adolygiad Cyflym fod y Fferylllydd Arweiniol ar Ddiogelwch Cleifion wedi dweud, hyd yn oed pe bai'r feddyginiaeth wedi cael ei hystyried fel presgripsiwn newydd, byddai'r un faint o'r feddyginiaeth yn dal wedi'i rhagnodi i Mr P.

33. Cyflwynodd y Bwrdd Iechyd ddatganiad gan yr Ymgynghorydd. Yn ddo dywedodd ei fod wedi ffurfio perthynas meddyg-claf dda â Mr P. Dywedodd fod Mr P wedi sôn llawer wrtho am ei broblemau, a'i fod wedi rhoi sicrwydd iddo y byddai'n gwneud ei orau i'w helpu. Dywedodd yr Ymgynghorydd ei fod ar 14 Mawrth wedi gorffen gweld Mr P ar y ward a'i fod ar fin gweld y claf nesaf pan gafodd ei alw'n ôl gan Mr P a'i fod wedi gofyn iddo a gâi rywfaint o Sevredol, gan ei fod yn arfer ei gymryd at ei gur pen. Dywedodd nad oedd ganddo reswm i amau Mr P am ei bod yn ymddangos bod ganddo beth gwybodaeth am y cyffur, am ei fod wedi gofyn amdano wrth ei enw brand.

34. Dywedodd yr Ymgynghorydd ei fod wedi rhagnodi dos bychan ar gyfer defnydd claf mewnol yn bennaf, ac nad oedd y dos yn ddigon i achosi risg o gaethiwed. Dywedodd nad oedd Mr P wedi gofyn am gael rhywfaint i fynd adref a phe bai wedi gwneud hynny y byddai wedi codi cwestiynau ac y byddai'n annhebygol o fod wedi'i rhagnodi ar sail hynny'n unig. Dywedodd "Nid oeddwn yn teimlo ar yr adeg hon bod y dos bychan hwn o Sevredol yn bresgripsiwn anniogel. Pe bai Mr P wedi gofyn am rywfaint "i fynd adref", a fuaswn wedi'i rhagnodi, na fuaswn i ddim. Pe bawn yn gwybod nad oedd arno cyn cael ei dderbyn i'r ysbyty, ni fuasai wedi'i gael gan y buaswn wedi dechrau ag analgesia syml. Roedd y presgripsiwn ar gyfer hyn yn ôl yr

angen ar ddos isel yn yr ysbyty.” Dywedodd y Bwrdd Iechyd ei bod yn anffodus fod Sevredol wedi’i roi i Mr P i fynd adref gan y meddyg rhyddhau, er mai bwriad yr Ymgynghorydd oedd rhagnodi’r feddyginiaeth i’w chymryd yn ôl yr angen yn yr Ysbyty.

35. Dywedodd y Bwrdd Iechyd na chafodd Mrs P ei hysbysu o’r presgripsiwn am fod gan Mr P alluedd meddyliol ac na fyddai’n arferol i hysbysu teuluoedd yn yr amgylchiadau hynny. Dywedodd y byddai copi o’r presgripsiwn rhyddhau wedi bod ar gael i Mrs P ei ddarllen (dywedodd Mrs P na chafodd Mr P gopi ohono). Roedd y Bwrdd Iechyd wedi cydnabod na chafod Mr P ei gynghori ar risgiau meddyginiaethau sy’n seiliedig ar forffin yn unol â Chanllaw Morffin y BNF. Dywedodd mai’r rheswm am hyn oedd ei fod yn credu bod Mr P wedi bod yn cymryd y feddyginiaeth cyn cael ei dderbyn i’r ysbyty.

Cyngor proffesiynol

36. Gofynnwyd i’r Cynghorwyr ystyried a oedd y gofal a’r driniaeth, heb ddoethinebu wrth edrych yn ôl, wedi bod yn briodol yn y sefyllfa y cwynwyd amdani. Mae’r Ombwdsmon yn penderfynu a oedd safon y gofal yn briodol drwy gyfeirio at safonau cenedlaethol perthnasol neu ganllawiau rheoleiddiol, proffesiynol neu statudol a oedd yn gymwys ar adeg y digwyddiadau a oedd yn sail i’r gŵyn.

Y Cynghorydd Fferyllol

37. Dywedodd y Cynghorydd nad oedd yn glinigol briodol nac yn ddiogel i’r tîm fferyllol gyhoeddi presgripsiwn Sevredol i Mr P ar 14 Mawrth. Dywedodd nad oedd gan y tîm fferyllol ddigon o wybodaeth i gyflenwi’n ddiogel o ran y rhesymau clinigol am y driniaeth ac elfennau fferyllol y feddyginiaeth.

38. Dywedodd y Cynghorydd fod cyfrifoldeb ar y tîm fferyllol i gadarnhau priodoldeb clinigol meddyginiaeth a ragnodir i glaf. Eglurodd y dylai’r tîm fferyllol gysoni meddyginiaethau o fewn 24 awr ar ôl derbyn claf gan gyfeirio at o leiaf 2 ffynhonnell o wybodaeth ddibynadwy. Dylai’r fferyllol wedyn adolygu’r wybodaeth a gasglwyd a rhoi sylw i unrhyw broblemau a amlygwyd cyn cadarnhau bod y broses gysoni wedi’i chwblhau. Yn achos Mr P, cafodd hyn ei gadarnhau ar 12 Mawrth.

39. Dywedodd y Cyngorydd y dylai'r ffaith nad oedd y broses gysoni wedi dangos unrhyw gyfeiriad i awgrymu bod Sevredol wedi'i ragnodi o'r blaen fod wedi gwneud i'r tîm fferyllol gwestiynu priodoldeb y cais ar 14 Mawrth. Dywedodd fod diffyg unrhyw ddogfennaeth yn dangos rheswm dros gyflenwi opioid cryf i drin meigrin fod wedi gwneud i'r tîm fferyllol ofyn am ragor o wybodaeth gan dîm yr Ymgynghorydd.

40. Nododd y Cyngorydd nad oedd cyfeiriad yng nghofnodion clinigol yr Ysbyty fod gan Mr P hanes o feigrin. Pan gafodd Mr P ei dderbyn, gwadodd ei fod wedi dioddef cur pen yn ddiweddar. Yn ei phrofiad hi, dywedodd nad oedd y defnydd o opioidau, a morffin yn enwedig, fel un ffordd i reoli cur pen neu feigrin yn dilyn yr arferion cyfredol. Dywedodd y disgwyliid gweld peth hanes o opioid gwannach yn cael ei ddefnyddio fel codeine ynghyd â pharacetamol. Dywedodd fod Canllawiau Reoli Poen Ffarmacoleg Cymru Gyfan yn datgan y dylai therapi opioid gael ei ddefnyddio'n unig ar gyfer symptomau sy'n parhau er gwaethaf triniaethau cyntaf. Hefyd, nododd fod CKS Meigrin NICE yn argymhell analgesia syml (meddyginiaethau a defnyddir i leddfu poen) yn y lle cyntaf. Hefyd, nododd fod Canllaw NICE ar Gur Pen yn dweud na ddylai opioidau gael eu defnyddio fel triniaeth aciwt ar gyfer cur pen tyndra, cur pen clwstwr na meigrin.

41. Dywedodd y Cyngorydd nad oedd wedi gweld dim tystiolaeth fod Mr P wedi defnyddio analgesia yn y gorffennol at gur pen neu feigrin heblaw am y paracetamol roedd wedi'i brynu dros y cownter. Ar ôl sylweddoli nad opioidau yw'r driniaeth arferol ar gyfer meigrin na chur pen, mi ddylai'r tîm fferyllol fod wedi ymchwilio i'r rhesymau clinigol am y cais. Dywedodd y Cyngorydd y byddai hyn wedi digwydd pe bai Sevredol wedi cael ei ragnodi os oedd cais yn cael ei wneud amdano fel ymyriad newydd. Nododd y Cyngorydd nad oedd dim rhyngweithio clinigol arwyddocaol rhwng Sevredol a'r meddyginiaethau eraill a ragnodwyd i Mr P ac nad oedd dim yn ei ffisioleg a fyddai wedi cynyddu'r risg o docsigrwydd morffin.

42. Dywedodd y Cyngorydd yr ymddengys nad oedd y tîm fferyllol wedi cynnal nifer o wiriadau y gellid eu disgwyl cyn cyhoeddi'r presgripsiwn. Yn gyntaf, dywedodd y dylai fferylllydd adolygu'r feddyginiaeth y gwnaed cais amdani ar y ward a llofnodi blwch gwirio'r fferylllydd ar y siart meddyginiaethau. Fodd bynnag, nid oedd y blwch gwirio wedi'i lofnodi ar y siart perthnasol. Dywedodd mai diben yr adolygiad oedd sicrhau bod y

presgripsiwn yn glinigol briodol ac y dylai hynny gynnwys gwirio nodiadau a hanes cyffuriau'r claf, gwirio â'r rhagnodydd, a gwirio â'r practis meddyg teulu neu'r fferyllfa gymunedol.

43. Dywedodd y Cynghorydd y byddai fferylllydd y ward fel arfer yn gwirio'r driniaeth arferol ar gyfer cur pen cronig/meigryn, yn gwirio gwaed y claf ac yn gwirio am ryngweithio posibl â meddyginiaethau eraill. Gan fod hwn yn gyffur a reolir, byddai disgwyl i'r gwiriad gynnwys camau a nodir yng Nghanllaw NICE ar gyffuriau a reolir. Mae'r rhain yn cynnwys:

- dogfennu'n glir yr arwyddion a'r rheolaeth yn achos y cyffur a reolir yng nghofnod gofal y claf
- trafod â'r unigolyn y trefniadau ar gyfer adolygu a monitro triniaeth
- bod yn barod i drafod y penderfyniad rhagnodi â gweithwyr iechyd proffesiynol eraill os gofynnir am ragor o wybodaeth am y presgripsiwn
- gwirio bod y presgripsiwn yn briodol i anghenion clinigol cyfredol y claf a sicrhau bod y rheswm am y presgripsiwn wedi'i gofnodi'n eglur yn y cofnodion.

44. Nododd y Cynghorydd, ar sail y cofnodion meddygol, ei bod yn debygol bod y siart cyffuriau wedi'i gwblhau gan dîm yr Ymgynghorydd tua 10:15 ar 14 Mawrth. Cafodd y presgripsiwn rhyddhau ei gofnodi ar system olrhain presgripsiynau'r tîm fferyllol am 16:16. Dywedodd fod nifer o resymau gweithredol a allai egluro pam fod blwch gwirio'r fferylllydd yn dal heb ei lofnodi cyn i'r presgripsiwn rhyddhau gael ei baratoi. Er enghraifft, mae'n bosibl nad oedd fferylllydd ar gael i weithio yn y ward.

45. Cyn y gall presgripsiwn rhyddhau gael ei brosesu a'i ryddhau i'r claf i fynd adref, dywedodd y Cynghorydd fod yn rhaid i fferylllydd gynnal adolygiad clinigol o'r meddyginiaethau. Dywedodd y Cynghorydd fod y ffaith nad oedd y blwch gwirio ar y siart meddyginiaethau wedi'i lofnodi'n dangos nad oedd y gwiriadau gofynnol y cyfeirir atynt ym mharagraff 43 wedi'u gwneud ar y ward. Felly, dylai'r fferylllydd a oedd yn adolygu'r meddyginiaethau rhyddhau fod wedi cynnal y gwiriadau hyn.

46. Dywedodd y Cynghorydd y dylai'r dos a'r fformiwleiddiad (tabledi, capsiwl, hylif neu ryddhau dan reolaeth) fod wedi'u cadarnhau â'r rhagnodydd, practis y meddyg teulu neu'r claf. Dywedodd fod yn rhaid datgan y fformiwleiddiad bob amser wrth ragnodi cyffuriau a reolir i gleifion allanol neu bresgripsiynau rhyddhau, ond nad oedd hyn yn gymwys yn achos presgripsiynau at ddefnydd cleifion mewnol yn unig. Yn yr achos hwn roedd y siart meddyginiaethau'n nodi'r dull gweinyddu (drwy'r geg) ond nid y math. Nododd y Cynghorydd fod y dos pob 4 awr wedi'i gadarnhau ar y siart mewn inc gwyrdd. Dywedodd ei bod yn tybio fod hyn wedi cael ei wneud gan dechnegydd fferyllfa am y byddai fferyllydd a fyddai'n adolygu'r siart yn debygol o lofnodi'r blwch gwirio.

47. Eglurodd y Cynghorydd fod morffin sylffad ar gael fel hylif i'w gymryd drwy'r geg (hylif Oramorph 10 mg/5 ml), tabledi rhyddhau ar unwaith (tabledi Sevredol 10 mg) a pharatoadau sy'n rhyddhau dan reolaeth (capsiwlau Zomorph 10 mg). Dywedodd fod y rhan fwyaf o'r morffin a ragnodir yn digwydd drwy ragnodi'r brand oherwydd y goblygiadau i ddiogelwch o ragnodi fformiwleiddiad â nodweddion rhyddhau sy'n wahanol i'r hyn sy'n gyfarwydd i'r claf. Nododd fod polisi Meddyginiaethau'r Bwrdd Iechyd yn datgan yn glir fod angen rhagnodi'n ôl brand os oes gwahaniaeth mewn bioargaeledd (pa mor gyflym mae cynhwysyn actif yn cael ei amsugno i lif y gwaed) rhwng brandiau o'r un feddyginiaeth. Gan fod y cais wedi'i restru yn yr adran "pan fydd angen" o'r siart meddyginiaethau gyda dos pob 4 awr, byddai wedi bod yn rhesymol i'r tîm fferyllol dybio bod y rhagnodydd wedi bwriadu i fformiwleiddiad rhyddhau ar unwaith gael ei gyflenwi. Fodd bynnag, nid oedd y siart cyffuriau'n dangos ai tabledi ynteu hylif a ddylai gael ei gyflenwi.

48. Dywedodd y Cynghorydd nad oedd yn amlwg sut y cafodd y cais am forffin sylffad 10mg ar y siart meddyginiaethau ei drawsgrifio gan y tîm fferyllol i ryddhau'r tabledi Sevredol os nad oedd y siart wedi'i gadarnhau gyda'r brand neu'r fformiwleiddiad. Gan nad oedd yr wybodaeth hon wedi'i chofnodi'n unman arall yn y nodiadau clinigol, dywedodd fod sgwrs wedi gorfod digwydd rhwng yr unigolyn a oedd wedi paratoi'r presgripsiwn rhyddhau ac aelod o dîm yr Ymgynghorydd, neu Mr P, i gadarnhau'r brand. Dywedodd y Cynghorydd y dylai'r unigolyn yn y tîm fferyllol fod wedi gofyn ar yr adeg hon am ragor o wybodaeth i gael sicrwydd am briodoldeb y presgripsiwn.

49. Dywedodd y Cynghorydd y byddai disgwyl hefyd i'r tîm fferyllol fod wedi cadarnhau pa bryd yr oedd Mr P wedi cael Sevredol o'r blaen ac os oedd wedi cael cyflenwad gartref. Roedd hyn yn bwysig i atal cleifion rhag cadw gormod o feddyginiaethau, sy'n gallu bod yn beryglus ac yn wastraffus. Hefyd, o gofio bod gweinyddu cyffuriau a reolir yn gallu golygu oedi cyn rhyddhau o ganlyniad i'r gwiriadau ychwanegol sydd eu hangen, roedd yn bwysig gwirio bod gwir angen am y cyffur a reolir. Dywedodd y byddai ffonio'r practis meddyg teulu wedi bod yn fuddiol, ac y dylai hyn fod yn bosibl er nad oedd yr wybodaeth o bractis meddyg teulu yn Lloegr ar gael drwy Borth Clinigol Cymru (system cofnodion cleifion electronig a ddefnyddir gan GIG Cymru). Dywedodd y byddai'r gwiriadau hyn wedi dangos nad oedd Sevredol wedi cael ei ragnodi o'r blaen, ac y byddai hynny wedi codi amheuan am briodoldeb y presgripsiwn.

50. Dywedodd y Cynghorydd gan fod y rhyddhau'n cael ei baratoi tua diwedd y diwrnod gwaith, efallai bod pwysau i brosesu'r rhyddhau'n gyflym. Yn ei barn hi, dywedodd y byddai wedi bod yn fwy diogel i ryddhau Mr P heb gyflenwi'r morffin nes i wiriadau priodol gael eu cwblhau. Gallai paracetamol fod wedi'i gyflenwi yn ei le.

51. Dywedodd y Cynghorydd fod y tîm meddygol a'r tîm fferyllol yn gweithio ar wahân i'w gilydd a bod hynny wedi arwain at wneud tybiaethau am Mr P a'i feddyginiaethau. Ni chafodd gwiriadau digonol eu gwneud ac o'r herwydd cafodd meddyginiaeth ei chyflenwi nad oedd yn ddiogel. Er mwyn gwella'r gwasanaeth dywedodd y dylai'r tîm fferyllol fyfyrir ar Safonau 2 a 5 o Safonau'r GPhC.

52. Eglurodd y Cynghorydd fod Safon 2 yn datgan bod yn rhaid i weithwyr fferyllol proffesiynol weithio mewn partneriaeth ag eraill gan fod iechyd, diogelwch a llesiant pobl yn ddibynnol ar y partneriaethau hyn lle mae pawb yn cyfrannu at ddarparu'r gofal sydd ei angen ar yr unigolyn. Mae hyn yn cynnwys gweithwyr proffesiynol a thimau gofal iechyd eraill, gofawyr a pherthnasau. Dywedodd y Cynghorydd y byddai'n fuddiol dros ben pe bai'r tîm fferyllol a thîm yr Ymgynghorydd yn gweithio â'i gilydd ar y ward er mwyn manteisio ar arbenigedd y ddau broffesiwn i sicrhau profiad gwell i'r cleifion. Dywedodd y byddai dull amlddisgyblaeth wedi bod yn gyfle ardderchog i ddysgu am reoli cur pen mewn ffordd therapiwtig.

53. Nododd y Cynghorydd fod Safon 5 yn datgan bod yn rhaid i weithwyr fferyllol proffesiynol ddefnyddio eu crebwyll i ddarparu gofal diogel ac effeithiol. I gyflawni'r safon hon, rhaid i weithwyr fferyllol proffesiynol sicrhau bod ganddynt yr wybodaeth sydd ei hangen i ddarparu gofal priodol. Yn achos Mr P nid oedd y tîm fferyllol wedi cymryd camau i gael yr wybodaeth oedd ei hangen i sicrhau bod Sevredol yn cael ei gyflenwi'n ddiogel.

54. Dywedodd y Cynghorydd y dylid gwneud pob ymdrech i siarad â chlaf am eu meddyginiaethau cyn eu rhyddhau. Dywedodd nad oedd cynghori wedi digwydd oherwydd y dybiaeth fod Mr P yn cymryd y feddyginiaeth eisoes. Fodd bynnag, nododd fod y presgripsiwn rhyddhau'n cynnwys meddyginiaeth newydd, thiamin, ac er bod warfarin yn gyffur cyn derbyn, mi fyddai angen i Mr P wybod nad oedd y dos wedi newid. Dywedodd y Cynghorydd y dylai'r tîm fferyllol fod wedi siarad â Mr P i drafod y pwyntiau hyn.

55. Yn olaf, nododd y Cynghorydd fod polisi cysoni meddyginiaethau Amlddisgyblaethol Cymru Gyfan yn argymhell pan fydd cleifion yn cael eu rhyddhau o ysbyty y dylid ystyried defnyddio gwasanaeth Adolygiad Meddyginiaethau Rhyddhau ("DMR") fel ffordd o rannu unrhyw faterion cysoni meddyginiaethau ar gyfer cleifion priodol. Mewn gofal sylfaenol dywedodd fod yn rhaid i weithwyr gofal iechyd proffesiynol sy'n gwneud gwaith cysoni meddyginiaethau wneud hyn yn achos pawb sydd wedi cael eu rhyddhau o ysbyty neu leoliad arall. Dylai cysoni meddyginiaethau ddigwydd cyn gynted ag y bo'n ymarferol bosibl, cyn cyhoeddi presgripsiwn neu gyflenwad newydd o feddyginiaethau ac o fewn wythnos ar ôl i'r practis meddyg teulu gael ei hysbysu bod y claf yn cael ei ryddhau. Fodd bynnag, nododd y Cynghorydd fod Mr P yn byw yn Lloegr ac er bod Gwasanaeth Meddyginiaethau Rhyddhau ("DMS") cyfatebol a oedd yn derbyn atgyfeiriadau gan Ymddiriedolaethau GIG yn Lloegr, nid oedd yn amlwg sut y gallai bwrdd iechyd yng Nghymru atgyfeirio claf.

Y Cynghorydd Ymarfer Cyffredinol

56. Gofynnwyd i'r Cynghorydd a oedd y tîm meddygol yn gweithredu o fewn terfynau gofal priodol wrth ragnodi morffin sylffad i Mr P. Dywedodd y Cynghorydd ei bod yn anodd cynnig sylwadau ar briodoldeb y presgripsiwn a roddwyd am nad oedd y rhesymau clinigol wedi'u dogfennu ar y pryd. Dywedodd na allai ddod o hyd i unrhyw ddogfennaeth yn ymwneud â dewis yr Ymgynghorydd i ragnodi morffin, y rheswm dros y presgripsiwn morffin, ei drafodaeth â'r claf, amserlen y dosau ar gyfer y morffin, yr hyd a fwriadwyd ar gyfer y presgripsiwn, neu a oedd bwriad i'w barhau ar ôl rhyddhau, hynny yw, ei ryddhau gyda morffin i fynd adref.

57. Nododd y Cynghorydd fod Canllaw Ymarfer Da'r GMC (paragraffau 69-71) yn pwysleisio'r angen i ffisegwyr gadw cofnodion manwl o'r gweithgarwch, gan sicrhau bod digon o fanylder sy'n cynnwys canfyddiadau clinigol, ymchwiliadau, a thriniaethau a ddarparwyd neu a weinyddwyd. Ar ôl ystyried hyn i gyd, dywedodd y Cynghorydd nad oedd yr Ymgynghorydd a'i dîm wedi cyrraedd y safon a ddisgwyliid ar gyfer dogfennu ei benderfyniadau clinigol. Nododd fod dogfennaeth yn aml yn cael ei chwblhau gan feddyg preswyl (iau) a bod eu sgiliau i ddogfennu ymgynghoriad yn amrywiol iawn, a bod cyfyngiadau amser yn aml yn atal ymgynghorwyr rhag adolygu popeth a gofnodwyd gan feddygon preswyl. Er hynny mewn sefyllfaoedd lle mae amser mor brin, roedd yn hanfodol nodi'r elfennau mwyaf arwyddocaol a oedd angen eu dogfennu, ac yn yr achos hwn, nid oedd hynny wedi digwydd.

58. Nododd y Cynghorydd mai'r hyn a roddwyd ar gyfer y presgripsiwn ar y siart meddyginiaethau oedd meigrin ac fe gofnodwyd ar yr un dudalen fod paracetamol yn cael ei ragnodi i Mr P yn ôl yr angen a bod ei angen arno ar 6 achlysur yn ystod ei gyfnod yn yr ysbyty, gan gynnwys bore 14 Mawrth. Dywedodd y Cynghorydd er nad oedd sôn yn y cofnod o rownd ward yr Ymgynghorydd ar 14 Mawrth fod Mr P yn cwyno ei fod mewn poen, roedd yn rhesymol i gredu bod cur pen yn broblem barhaus iddo, o ystyried yr adroddiad ar 10 Mawrth o gur pen parhaus ers ei dderbyn. Nod oedd cyfeiriad yn y nodiadau derbyn bod Mr P ar forffin ar adeg ei dderbyn, ac nid oedd cyfeiriad ychwaith at hanes o feigrin.

59. Nododd y Cyngorydd fod CKS Meigrin NICE a Chanllaw NICE ar Gur Pen yn datgan na ddylai opiadau gael eu defnyddio at feigrin nac ar gyfer cur pen yn dilyn strôc, beth bynnag yr achos. Fodd bynnag yn ei brofiad ef, dywedodd ei bod yn arferol yn ymarferol, lle gwelwyd fod meddyginiaethau'n fuddiol yn y gymuned i barhau i'w gweinyddu yn yr ysbyty.

60. Yn ôl y Cyngorydd, os tybir fod yr Ymgynghorydd wedi cael ar ddeall fod Mr P yn cymryd morffin sylffad yn y gymuned cyn ei dderbyn i'r ysbyty, a'i fod wedi lleddfu poen iddo, roedd yn rhesymol i'w ragnodi iddo fel claf mewnol at y cur pen mynych roedd wedi'i brofi ers ei dderbyn. Hyd yn oed os oedd yr Ymgynghorydd yn gwybod nad oedd Mr P yn cymryd morffin cyn cael ei dderbyn, mae'n bosibl y gallai'r presgripsiwn am forffin at ddefnydd claf mewnol fod yn briodol os barnwyd fod angen y morffin i ymdopi â'r boen.

61. Dywedodd y Cyngorydd nad oedd y gwiriadau a gyflawnwyd gan dîm yr Ymgynghorydd cyn trefnu'r presgripsiwn yn gyflawn ond eu bod yn briodol am fod y presgripsiwn ar gyfer morffin wedi'i fwriadu at gyfer claf mewnol. Dywedodd ei bod yn ymddangos nad oedd yr Ymgynghorydd wedi bwriadu rhyddhau Mr P gyda'r feddyginiaeth hon. Dywedodd pe bai wedi bwriadu rhagnodi'r feddyginiaeth hon i Mr P i fynd adref, hyd yn oed am gyfnod byr yn unig, byddai'r Ymgynghorydd wedi gorfod bod yn bwyllog ac ystyried y gwiriadau a'r rhagofalon a geir yng Nghanllaw Presgripsiynau'r GMC, canllaw NICE ar gyffuriau a reolir, canllaw NICE ar feddyginiaethau sy'n achosi dibyniaeth a Chanllaw Morffin y BNF. Byddai hyn wedi cynnwys yr angen i gynghori Mr P ar beryglon posibl morffin a'i gynghori rhag defnydd hir o'r feddyginiaeth.

62. Yn yr amgylchiadau hyn dywedodd y Cyngorydd y byddai disgwyliad i gysylltu â phractis meddyg teulu Mr P i'w hysbysu ei fod yn cymryd morffin yn y gymuned a, hyd yn oed os oedd, i gwestiynu doethineb hynny ac i awgrymu cynllun yn y crynodeb rhyddhau i beidio â rhoi morffin yn y gymuned.

63. Dywedodd y Cyngorydd fod canllaw NICE ar feddyginiaethau sy'n achosi dibyniaeth yn argymhell bod yr holl opsiynau rheoli addas yn cael eu trafod a'u cynnig i'r unigolyn cyn dechrau neu barhau triniaeth ag opioid. Nododd fod y canllaw yn datgan y dylai clinigwyr ystyried a oes unrhyw

ffactorau a allai gynyddu risg yr unigolyn o ddatblygu problemau sy'n gysylltiedig â dibyniaeth, gan gynnwys hanes o broblemau iechyd meddwl neu gamddefnyddio alcohol, ond mae'n rhybuddio rhag defnyddio un o'r rhesymau hyn fel yr unig achos dros beidio rhagnodi meddyginiaethau. Nododd y Cyngorydd fod Mr P wedi cael ei adolygu gan y timau cyswllt seiciatreg ac alcohol.

64. Dywedodd y Cyngorydd fod Canllaw Presgripsiynau'r GMC yn datgan "before proposing, prescribing or providing medications, treatment or devices, you must consider whether the information you have is sufficient and reliable enough to enable you to provide safe care". Dywedodd ei bod yn rhesymol ddigon i'r Ymgynghorydd benderfynu bod ganddo ddigon o wybodaeth i wneud presgripsiwn at ddefnydd yn yr ysbyty gan fod Mr P wedi dweud wrtho ei fod wedi bod yn cymryd Sevredol at gur pen yn y gymuned. Dywedodd fod yr Ymgynghorydd yn gyfarwydd â chefnidir clinigol Mr P a'i fod yn rhagnodi morffin ar ddos derbyniol, yn ôl yr angen.

65. Dywedodd y Cyngorydd nad oedd yr Ymgynghorydd wedi sylweddoli nad oedd yr wybodaeth a roddwyd gan Mr P yn ddibynadwy. Dywedodd ei bod yn arferol i dderbyn yr hyn a ddywed claf wrth glinigydd fel y gwirionedd oni bai bod rheswm i gredu bod y claf yn dweud anwiredd. Mae cwestiynu gonestrwydd claf heb reswm yn cymryd amser ac mae'n anymarferol a, hefyd, mae'n peryglu'r ymddiriedaeth yn y berthynas rhwng meddyg a chlaf. Dywedodd na fyddai gwirio cofnodion meddygol o reidrwydd wedi dangos bod gwybodaeth Mr P yn annibynadwy, am nad yw cofnodion bod amser yn gywir na chyflawn.

66. Dywedodd y Cyngorydd fod meddyginiaethau i gleifion fynd adref â hwy wedi'u hysgrifennu fel arfer gan feddygon preswyl neu fferyllwyr a'u bod yn cael eu gwirio gan fferyllwyr; nid ydynt yn cael eu gwirio gan ymgynghorwyr bob tro. Dywedodd pe bai'r Ymgynghorydd wedi bwriadu cyhoeddi'r presgripsiwn fel meddyginiaeth newydd, byddai'n dal i gael ei ystyried fel presgripsiwn priodol, am ei fod yn ddos cychwynnol derbyniol a dim ond 10 tabled a roddwyd i Mr P, a gyda 10mg bob 4 awr yn ôl yr angen, sy'n gyflenwad 2 ddiwrnod yn unig. Fodd bynnag, y gwahaniaeth wrth rhagnodi morffin fel meddyginiaeth ryddhau newydd yw y byddai'n rhaid i'r Ymgynghorydd fod yn ofalus, a gweithredu'n unol â'r canllaw perthnasol fel yr eglurwyd ym mharagraff 61 uchod.

67. Nododd y Cyngorydd fod canllaw NICE ar feddyginiaethau sy'n achosi dibyniaeth (paragraff 1.2.3) yn cynghori clinigwyr "during the first discussion about prescribing, give the person information and advice (in their preferred format) to help them balance the potential benefit of the medicine and other treatment options with the risk of long-term consequences". Dywedodd y Cyngorydd y byddai wedi bod yn arbennig o bwysig yn hyn o beth bod Mr P wedi cael yr wybodaeth hon. Nid oedd rhoi'r wybodaeth hon i deulu Mr P mor bwysig gan nad oedd Mr P yn ddryslyd. Fodd bynnag, pe bai amser yn caniatáu, byddai hynny'n arfer da.

Dadansoddiad a chasgliadau

68. Wrth ddod i fy nghasgliadau rwyf wedi ystyried y cyngor a gefais gan y Cynghorwyr, ac rwyf yn ei dderbyn. Fodd bynnag, fy nghasgliadau i ydynt. Nid wyf wedi cynnwys pob manylyn yr ymchwiliwyd iddynt ond rwyf yn fodlon nad oedd dim byd arwyddocaol wedi'u hepgor.

A oedd yn glinigol briodol i ragnodi Sevredol (morffin sylffad) i Mr P

69. Rwyf yn **cadarnhau'r** gŵyn hon. Yn y lle cyntaf, roedd cyfrifoldeb ar yr Ymgynghorydd a'i dîm i sicrhau bod y presgripsiwn y gofynnwyd amdano'n glinigol briodol. Ar ôl ystyried cyngor y Cyngorydd Ymarfer Cyffredinol, rwyf o'r farn nad oedd yr Ymgynghorydd a'i dîm wedi dogfennu'r rheswm dros ragnodi morffin sylffad. Roedd hyn yn mynd yn groes i Ganllaw Ymarfer Da'r GMC a'r dogfennau canllaw sy'n ymdrin â phresgripsiynau a restrir ym mharagraffau 4, 5 a 6. Felly bu methiant ar y pryd i ddangos bod y presgripsiwn yn glinigol briodol.

70. Dywedodd yr Ymgynghorydd mewn datganiadau diweddarach fod y presgripsiwn at ddefnydd claf mewnol ac nid i Mr P fynd adref gydag ef ar ôl ei ryddhau. Fodd bynnag, yn ôl y nodyn o rownd y ward ar 14 Mawrth y cynllun oedd bod Mr P yn cael ei ryddhau'n ddiweddarach y diwrnod hwnnw, yn amodol ar adolygiad seiciatreg. O gofio bod yr Ymgynghorydd yn amlwg yn bwriadu rhyddhau Mr P cyn hir, dylai fod yn ymwybodol o'r angen i gyfleu'n glir i'w dîm ac i'r tîm fferyllol na ddylai'r presgripsiwn y gofynnwyd amdano gael ei roi i Mr P i fynd adref. Nid oedd y bwriad hwn wedi'i gofnodi yn y nodiadau ac nid yw'n amlwg a oedd hyn wedi'i gyfleu ar lafar.

71. Mae'r Cynghorydd Ymarfer Cyffredinol wedi egluro y gallai'r presgripsiwn a'r dos fod yn glinigol briodol at ddefnydd claf mewnol, a hyd yn oed fel meddyginiaeth newydd ar adeg rhyddhau, os oes Mr P wedi bod yn ei chymryd yn y gymuned neu beidio. Fodd bynnag, yn fy marn i roedd yn amlwg yn glinigol amhriodol i roi Sevredol i Mr P i fynd adref yn groes i fwriadau'r Ymgynghorydd. Gellid bod wedi osgoi hyn pe bai'r rheswm am y presgripsiwn wedi'i ddogfennu a'i gyfleu i gydweithwyr ar y pryd. Mae polisi Meddyginiaethau'r Bwrdd lechyd yn datgan yn glir bod cyfrifoldeb ar ragnodwyr i sicrhau bod y meddyginiaethau a ragnodwyd ganddynt wedi cael eu hadolygu, ac y dylent gyfeirio at bresgripsiynau presennol y claf wrth wneud hynny. Efallai na fyddai presgripsiynau presennol Mr P i'w gweld ar ei gofnod electronig am fod ei bractis meddyg teulu yn Lloegr, ond nid oes dim i awgrymu bod yr Ymgynghorydd na'i dîm wedi ymdrechu i wirio'r wybodaeth hon. Beth bynnag am hynny, roedd y cofnodion o dderbyniad Mr P yn cynnwys digon o wybodaeth am ei feddyginiaethau ar adeg ei dderbyn.

72. Roedd yr un cyfrifoldeb ar y tîm fferyllol i gadarnhau bod y presgripsiwn yn briodol ac yn ddiogel i Mr P. Dywedodd yr Ymgynghorydd na fyddai wedi rhagnodi morffin sylffad i Mr P ar 14 Mawrth pe bai'n gwybod nad oedd yn bresgripsiwn cyn derbyn. Yn hytrach, mi fyddai wedi rhoi analgesia syml i Mr P i ddechrau. Roedd y tîm fferyllol, erbyn 12 Mawrth, wedi cwblhau proses cysoni meddyginiaethau a oedd wedi cadarnhau nad oedd morffin sylffad yn bresgripsiwn cyn derbyn. Gwela, gyda chyfeiriad at gyngor y Cynghorydd Fferyllol, fod y tîm fferyllol wedi colli nifer o gyfleoedd i gwestiynu'r presgripsiwn gyda thîm yr Ymgynghorydd ac i dynnu eu sylw at yr wybodaeth hanfodol hon.

73. Yn gyntaf, dylai'r tîm fferyllol fod wedi cynnal gwiriad clinigol o'r presgripsiwn ar y ward; byddai hyn wedi cynnwys gwirio nodiadau a hanes cyffuriau'r claf, gwirio â'r rhagnodydd a gwirio â'r practis meddyg teulu neu'r fferyllfa gymunedol. Byddai'n bwysig dros ben gwirio'r rheswm â'r rhagnodydd gan nad yw opioidau'n driniaeth arferol at feigryn na chur pen ac nad oedd dim cyfiawnhad clinigol dros y presgripsiwn yn y nodiadau. Mae'n debygol iawn y byddai gair byr â'r rhagnodydd i wirio'r rheswm dros y presgripsiwn wedi canfod nad oedd morffin sylffad yn feddyginiaeth cyn derbyn ac nad oedd yr Ymgynghorydd wedi bwriadu i'r feddyginiaeth gael ei chyhoeddi fel cyffur rhyddhau.

74. Ymddengys o'r cofnodion nad oedd y siart meddyginiaethau wedi'i wirio gan fferylllydd ward. Mae'r ffaith na ddigwyddodd hyn yn golygu ei bod yn arbennig o bwysig bod y gwiriadau priodol wedi'u cynnal gan y tîm fferyllol cyn rhoi'r meddyginiaethau ryddhau. Gan fod cais wedi'i wneud am gyffur a reolir, roedd disgwyl y cymerid camau ychwanegol i sicrhau bod y presgripsiwn o Sevredol yn ddiogel (gweler paragraff 43). Gan ystyried cyngor y Cynghorydd Fferyllol gwelaf fod methiant i gynnal y gwiriadau disgwylledig cyn cyhoeddi'r presgripsiwn.

75. Yn yr amgylchiadau, ac o gofio bod cais wedi'i wneud am gyffur a reolir, byddai disgwyl i'r tîm fferyllol gadarnhau bod y claf wedi cael Sevredol o'r blaen. Nid oedd yr wybodaeth a roddwyd gan Mr P i'r Ymgynghorydd fod Sevredol yn feddyginiaeth cyn derbyn yn cyd-fynd â'r rhestr o feddyginiaethau a gadarnhawyd gan y broses gysoni. Dylid wedi tynnu sylw at yr anghysondeb hwn yn ystod yr adolygiad o feddyginiaeth ryddhau a dylai fod wedi ysgogi'r tîm fferyllol i wirio pa bryd y cafodd y presgripsiwn diwethaf ei gyhoeddi. Rwyf yn cytuno â'r Cynghorydd Fferyllol y dylai wedi bod yn bosibl i ffonio'r practis meddyg teulu neu'r fferyllfa gymunedol i gadarnhau hyn. Os nad oedd hyn yn bosibl oherwydd yr adeg o'r dydd, dylai Mr P fod wedi'i ryddhau heb bresgripsiwn neu dylid bod wedi oedi cyn ei ryddhau.

76. Dywedodd y Bwrdd Iechyd na fyddai'r tîm fferyllol yn gallu dweud o'r daflen ryddhau interim a ddarparwyd gan y tîm meddygol a oedd y feddyginiaeth yn "cyffur cyn derbyn sy'n parhau" ynteu "wedi'i dechrau yn yr ysbyty" ond nad oedd yn rhaid cael yr wybodaeth hon i gadarnhau a oedd y presgripsiwn yn glinigol briodol. Yn ôl yr Adolygiad Cyflym hyd yn oed pe bai'r presgripsiwn wedi cael ei gategoreiddio fel meddyginiaeth newydd, byddai'r un maint wedi cael ei gyflenwi i Mr P. Mae hyn yn diystyru'r ffaith nad oedd yr Ymgynghorydd wedi gwneud cais am y feddyginiaeth fel presgripsiwn newydd ac nid oedd wedi bwriadu iddi gael ei chyflenwi i Mr P ar adeg ei ryddhau: oherwydd hynny roedd yn amlwg nad oedd yn glinigol briodol i gyflenwi meddyginiaeth a oedd yn groes i fwriad y rhagnodydd.

77. Er bod yr awydd i ysgafnhau'r baich gweinyddol ar glinigwyr yn ddealladwy, mae achos Mr P yn dangos arwyddocâd peidio ei gwneud yn ofynnol i ragnodwyr ddangos statws meddyginiaethau (cyn derbyn neu newydd) ar y daflen ryddhau interim. Pe bai'r wybodaeth hon wedi'i

chynnwys yn y cais interim byddai'r tîm fferyllol wedi'u hamlygu i'r ffaith bod y presgripsiwn yn deillio o gamddealltwriaeth yr Ymgynghorydd fod Mr P wedi bod yn cymryd morffin yn y gymuned. Erbyn i'r categori gael ei gofnodi ar y llythyr rhyddhau terfynol ar 18 Mawrth roedd Mr P wedi cael ei ryddhau, ac yn anffodus roedd wedi marw. Mae'n ymddangos imi ei bod yn bwysig dros ben bod y tîm fferyllol yn ymwybodol o'r categori a fwriedir ar adeg rhyddhau pan fyddant yn cyflenwi cyffuriau a reolir.

78. Rwyf yn cytuno â'r Cynghorydd Fferyllol ei bod yn debygol bod aelod o'r tîm fferyllol wedi siarad ag aelod o dîm yr Ymgynghorydd neu â Mr P i gadarnhau'r enw brand neu'r fformiwleiddiad ar gyfer y presgripsiwn am nad oedd y rhain wedi'u nodi ar y siart meddyginiaethau (sydd ynddo'i hun yn mynd yn groes i bolisi Meddyginiaethau'r Bwrdd Iechyd). Drwy hynny, collwyd cyfle allweddol i gasglu mwy o wybodaeth am natur a diben y presgripsiwn. Ar yr adeg rhyddhau ni allai'r tîm fferyllol fod â sicrwydd bod rhagnodi Sevredol yn ddiogel nac yn briodol. Roedd hyn yn fethiant gwasanaeth sylweddol.

79. O ran cyngor y Cynghorydd Fferyllol, rwyf o'r farn bod rhagnodi Sevredol ar gam i Mr B yn ganlyniad methiant gan y timau meddygol a fferyllol i gydweithio'n ddigon da â'i gilydd. Pe bai cydweithrediad a chyfathrebu amlddisgyblaethol wedi digwydd, mae'n debygol na fyddai'r presgripsiwn wedi'i gyhoeddi. Yn hytrach, cafodd ei roi ar gam i Mr P, yn groes i fwriadau'r rhagnodydd a heb ystyried y risgiau'n bwyllog a manwl, fel sy'n ofynnol yn ôl y canllaw perthnasol. Roedd yn golygu hefyd na chafodd Mr P fudd y cyngor a'r wybodaeth a fyddai'n cael eu rhoi fel arfer i glaf sy'n cael presgripsiwn newydd am gyffuriau a reolir. Roedd y rhain yn anghyfiawnderau difrifol i Mr P.

80. Wrth ragnodi morffin sylffad mae'n amlwg imi fod yr Ymgynghorydd wedi'i gymell i wneud cymaint ag y gallai i helpu Mr P. Roedd wedi meithrin perthynas dda â Mr P ac nid oedd ganddo achos i amau nad oedd Sevredol wedi'i ragnodi i Mr P yn ddiweddar a'i fod wedi bod yn ei gymryd a chael budd ohono cyn cael ei dderbyn i'r ysbyty. Rwyf yn cytuno bod y berthynas meddyg-claf yn seiliedig ar ymddiried a bod gan yr Ymgynghorydd bob hawl i gredu'r hyn a ddywedwyd wrtho. Fodd bynnag, mi fydd adegau pan na fydd gwybodaeth a roddir gan gleifion yn ddibynadwy neu'n anghywir. Dyna pam mae canllawiau a safonau perthnasol yn pwysleisio pwysigrwydd dogfennaeth briodol, cyfathrebu a gweithio amlddisgyblaethol i leihau'r

niwed i gleifion sy'n deillio o'r gymryd meddyginiaethau a ragnodir, yn enwedig yn achos meddyginiaethau a reolir fel morffin. Mae'n achos pryder bod y systemau i adolygu meddyginiaethau yn nhîm fferyllol y Bwrdd Iechyd, a ddylai ddiogelu cleifion, fod wedi methu droeon yn achos Mr P.

81. Dywedodd Mrs P ei bod yn teimlo fel pe bai gwn wedi'i lwytho wedi'i roi i Mr P. Mae ei sylwadau'n ddealladwy. Nid oedd yn ddiogel i roi Sevredol i Mr P, er mai dim ond cyflenwad 2 ddiwrnod ar ddos cymharol isel a roddwyd iddo. Yn achos rhywun na allai oddef morffin, roedd perygl o docsigrywdd morffin damweiniol, yn enwedig pan fo'r feddyginiaeth yn cael ei rhoi heb gyngor priodol ar sut i'w chymryd yn ddiogel.

82. Ni wyddys a oedd y morffin a oedd yng ngwaed Mr P ar adeg ei farwolaeth yn deillio o'r Sevredol a gyflenwyd iddo gan yr Ysbyty, ynteu o hen gyflenwad o Zomorph, neu gyfuniad o'r ddau. Nid oes modd gwybod o'r dystiolaeth sydd ar gael a fyddai gorddos Mr P wedi digwydd pe na bai'r Sevredol heb ei roi. Fodd bynnag, mae'n berthnasol nodi mai'r unig gyflenwad o forffin a gadarnhawyd fel bod ym meddiant Mr P ar y pryd oedd y Sevredol a gyflenwyd gan yr Ysbyty. Nodaf hefyd nad oes dim tystiolaeth ei fod wedi cymryd morffin cyn cael ei dderbyn i'r ysbyty, felly mae'n ymddangos yn debygol iawn nad oedd yn gallu goddef morffin. Mae'n rhesymol yn fy marn i ddod i'r casgliad fod cyflenwi morffin sylffad ar gam i Mr P a heb gyngor ac arweiniad priodol wedi cynyddu'n sylweddol y risg y byddai'n profi gorddos damweiniol. Roedd hyn yn anghyfiawnder eithriadol o ddifrifol i Mr P ac i'w deulu. Ar ôl ystyried difrifoldeb yr anghyfiawnderau hyn, rwyf o'r farn y byddai'n briodol i argymhell iawndal ariannol sylweddol i Mrs P.

A oedd Mr P a'i deulu wedi cael gwybodaeth a chymorth digonol i leihau'r risgiau i ddiogelwch a oedd yn gysylltiedig â rhagnodi Sevredol

83. Rwyf yn **cadarnhau'r** gŵyn hon. I bob pwrpas, cafodd y Sevredol ei ragnodi i Mr P fel presgripsiwn newydd, a phe bai wedi'i fwriadu felly byddai disgwyliad, yn ôl Canllaw Morffin y BNF, i gynghori Mr P "on the risks of tolerance and potentially fatal unintentional overdose, as well as signs and symptoms of overdose". Roedd y Bwrdd Iechyd wedi cydnabod bod methiant i gynghori Mr P ar y risgiau hyn. Dywedodd nad oedd hyn wedi digwydd am ei fod yn credu, ar gam, ei fod wedi bod yn cymryd

morffin sylffad cyn ei dderbyn i'r ysbyty. Fel yr eglurais uchod, dim ond gwiriadau sylfaenol gan y tîm fferyllol neu sgwrs fer rhwng y timau fferyllol a meddygol fyddai ei angen i ddangos bod y dybiaeth hon yn anghywir. Roedd y methiant i wneud hynny wedi arwain at yr anghyfiawnderau a ddisgrifiwyd uchod.

84. Rwyf yn derbyn cyngor y Cynghorydd y Ffisegwr Ymgynghorol na fyddai disgwyl i glinigwyr hysbysu Mrs P am y presgripsiwn, am nad oedd Mr P yn ddryslyd ar adeg ei ryddhau. Nodaf hefyd y byddai hyn yn arferiad i'w ganmol. Yn fy marn i, gallai ffordd fwy pwyllgor o gynllunio i ryddhau gynnwys gofyn am farn Mr P, yn enwedig o gofio'r hanes o bryderon am gam-drin sylweddau ac yfed alcohol yn y dirgel. Dywedodd y Bwrdd lechyd y gallai Mrs P fod wedi darllen y crynodeb rhyddhau. Roedd hyn yn diystyru'r ffaith na chafodd y crynodeb rhyddhau ei gwblhau tan ar ôl marwolaeth Mr P.

85. Yn anffodus, mae achos Mr P yn dangos realiti'r risgiau sy'n gysylltiedig â morffin sylffad. Mae hefyd yn dangos pwysigrwydd cyfathrebu da rhwng timau fferyllol a meddygol a sicrhau bod prosesau ar gyfer rhagnodi ac adolygu meddyginiaethau cyn rhyddhau'r claf yn rhai trylwyr. Ar ôl penderfynu bod Mr P yn addas i'w ryddhau, mae'n ddealladwy y byddai disgwyl i staff i weithio i drefnu hyn cyn gynted â phosibl. Y flaenoriaeth bob amser, fodd bynnag, ddylai sicrhau diogelwch y cleifion unigol drwy gynnal y gwiriadau angenrheidiol cyn rhagnodi meddyginiaethau ar adeg eu rhyddhau. Mae'n ymddangos y gallai awydd i drefnu rhyddhau cyflym fod yn ffactor pam nad oedd clinigwyr wedi talu sylw digonol i ddiogelwch presgripsiwn Sevredol Mr P. O gofio bod y Bwrdd lechyd yn debygol o brofi pwysau parhaus, ac eithafol ar adegau, ar eu gwasanaethau, rwyf yn pryderu bod perygl y gallai camgymeriadau tebyg gael eu hailadrodd.

86. Er bod y Bwrdd lechyd wedi cydnabod bod y presgripsiwn wedi'i gyhoeddi'n groes i fwriad y rhagnodydd, mae'n achos pryder ei fod yn mynnu bod y presgripsiwn yn briodol. Yn fy marn i, nid yw'r Bwrdd lechyd wedi rhoi cydnabyddiaeth na sylw priodol i ddifrifoldeb y methiannau cyfathrebu a phroses a arweiniodd at y camgymeriad hwn. Rwyf o'r farn bod difrifoldeb y methiannau yn achos Mr P yn ddigon i godi pryderon ehangach am ddigonolrwydd prosesau ac arferion gweithio'r Bwrdd lechyd o ran sicrhau rhagnodi diogel ar adeg rhyddhau cleifion. Mae'n amlwg bod

posibilrwydd o risg parhaus i ddiogelwch cleifion, yn enwedig yn achos meddyginiaethau a reolir. Rwyf yn cyhoeddi'r adroddiad hwn fel adroddiad budd y cyhoedd i roi cyfle i'r Bwrdd lechyd i ddangos ei ymrwymiad yn gyhoeddus i ddysgu gwersi o achos Mr P ac i roi sicrwydd na fydd y methiannau a amlygwyd yn yr adroddiad hwn yn digwydd eto. Rwyf hefyd yn credu bod angen annog dysgu ehangach yn sgil yr achos hwn ymhlith rhagnodwyr a thimau fferyllol mewn rhannau eraill o'r GIG yng Nghymru.

87. Yn olaf, er nad oedd delio â chwynion yn un o brif elfennau'r gŵyn yr ymchwiliad iddi, yn sgil yr wybodaeth a ddaeth i'r amlwg yn ystod yr ymchwiliad hwn, rhaid imi roi sylw i'r mater. Cyflwynwyd Dyletswydd Gonestrwydd GIG Cymru yng Nghymru ar 1 Ebrill 2023. Rwyf o'r farn nad oedd ymateb y Bwrdd lechyd i Mrs P yn cyrraedd y safonau sy'n cael eu hannog gan y ddyletswydd a'r hyn a bwriadwyd iddi ei gyflawni.

88. Roedd ymchwiliad i gwynion y Bwrdd lechyd wedi casglu tystiolaeth a oedd yn dangos yn amlwg bod cyffur a reolir wedi'i ragnodi i Mr P fynd adref ag ef yn groes i fwriad y meddyg rhagnodi, a bod hyn yn ganlyniad cyfres o fethiannau gan y timau meddygol a fferyllol. Mae'r ffaith na chafodd y methiannau hyn eu hamlygu yn yr Adolygiad Cyflym nac yn ymchwiliad y Bwrdd lechyd i'r gŵyn yn dangos nad oedd cwyn Mrs P yn destun adolygiad digon trylwyr na gwrthrychol. Yn benodol, rwyf yn credu bod cyfle wedi'i golli i gael cyngor meddygol annibynnol. Byddai hyn yn debygol o fod wedi amlygu'r methiannau yn ystod ymchwiliad y Bwrdd lechyd. Mae'r diffygion yn y ffordd yr ymdriniwyd â'r gŵyn yn fwy siomedig fyth o gofio bod y materion hyn wedi cael sylw fel pwyntiau dysgu allweddol yn yr Adroddiad Thematig

89. Dyma'r ail adroddiad budd y cyhoedd yn olynol imi ei gyhoeddi sy'n ymwneud â'r Bwrdd lechyd sydd wedi amlygu diffygion yn gysylltiedig â'r Ddyletswydd Gonestrwydd. Buaswn yn disgwyl i'r Bwrdd lechyd fanteisio ar y cyfle hwn i sicrhau bod gofynion ac ysbryd y Ddyletswydd Gonestrwydd wedi'u hymgorffori'n llawn yn niwylliant ac arferion gweithio pob dydd ei dimau clinigol a chwynion.

Argymhellion

90. Rwyf yn **argymell** y dylai'r Bwrdd lechyd o fewn **1 mis** i gyhoeddi'r adroddiad:

- a) Ymddiheuro i Mrs P am y methiannau a nodwyd yn yr adroddiad hwn, ac yn benodol, am ragnodi Sevredol i Mr P heb sicrhau ei fod yn ddiogel ac am fethu rhoi cyngor priodol iddo ar y risgiau a oedd ynghlwm wrth ei ddefnyddio.
- b) Talu iawndal o £2000 i Mrs P i adlewyrchu'r anghyfiawnderau a achoswyd i Mr P a'i deulu gan y methiannau hyn.
- c) Rhannu'r pwyntiau dysgu o'r achos hwn (mewn ffurf sy'n gwbl ddiennw) â'r holl staff meddygol a fferyllol a'u hatgoffa o'u cyfrifoldebau'n unol â chanllaw cyffuriau a reolir NICE, a Pholisi Meddyginiaethau'r Bwrdd lechyd. Dylai'r cyfathrebu hwn bwysleisio pwysigrwydd dogfennu'r rheswm clinigol dros ragnodi, a phwysleisio y dylai rhagnodi meddyginiaethau'n ddiogel fod yn flaenoriaeth, ac y dylai clinigwyr ystyried oedi cyn rhyddhau cleifion neu beidio â chyflenwi meddyginiaethau os oes angen er mwyn cyflawni hyn. Dylai hefyd bwysu arnynt i wneud pob ymdrech i gynghori cleifion am eu meddyginiaethau cyn eu rhyddhau, gyda blaenoriaeth i'r cleifion hynny ar feddyginiaethau risg uchel fel opioidau a gwrthgeulyddion a rhai y rhagnodir meddyginiaethau newydd iddynt.
- d) Rhannu'r adroddiad hwn â'r Ymgynghorydd er mwyn myfyrio fel rhan o ddatblygiad proffesiynol parhaus ac i'w ystyried yn eu harfarniad blynyddol nesaf.
- e) Rhannu'r adroddiad hwn â thîm ymchwilio i gwynion y Bwrdd lechyd i adolygu sut y cynhaliwyd ei ymchwiliad yn unol â'r Ddyletswydd Gonestrwydd ac i nodi pwyntiau dysgu i sicrhau nad yw methiannau tebyg yn cael eu methu yn y dyfodol. Dylai unrhyw welliannau a amlygir gael eu hymgorffori yn ei weithdrefn delio â chwynion a'u rhannu â fy swyddfa.

- f) Rhannu'r adroddiad hwn â Phwyllgorau Ansawdd a Diogelwch Cleifion ac Ansawdd a Risg y Bwrdd Iechyd i ystyried fy nghanfyddiadau a chynnwys yr hyn a ddysgwyd yn sgil yr argymhellion hyn yn ei adroddiad Dyletswydd Gonestrwydd Blyneddol.

91. Rwyf yn **argymell** y dylai'r Bwrdd Iechyd o fewn **6 mis** i gyhoeddi'r adroddiad:

- g) Cynnal adolygiad o brosesau ac arferion gweithio o fewn y timau meddygol a fferyllol i roi sylw i'r holl fethiannau a nodwyd yn yr adroddiad hwn. Dylai'r adolygiad gael ei gydlynu drwy gynnwys uwch reolwyr a'r cyfarwyddwyr meddygol o fewn y cyfarwyddiaethau perthnasol. Dylai:
- Ymchwilio a sicrhau bod pob presgripsiwn yn cael eu gwirio'n briodol a bod ymholiadau gan y rhagnodydd a'r fferylllydd ar y ward (gweler paragraff 43), a phan nad yw hyn yn bosibl bod yr un camau'n cael eu dilyn gan fferylllydd cyn rhyddhau'r claf.
 - Nodi camau i wella gweithio amlbroffesiwn a chyfathrebu rhwng timau meddygol a fferyllol.
 - Ystyried a ddylai'r broses i gwblhau crynodeb rhyddhau interim gael ei newid i gynnwys gwybodaeth i nodi a oedd y presgripsiwn yn newydd, ynteu wedi'i gyhoeddi cyn derbyn y claf i'r ysbyty.
 - Canfod a rhoi sylw i rwystrau sy'n atal clinigwyr rhag cael mynediad at wybodaeth am bresgripsiynau gan bractisau meddygon teulu yn Lloegr.
 - Ystyried a yw DMR yn cael eu defnyddio pan yn briodol, a mynd i'r afael ag unrhyw rwystrau rhag eu defnyddio yn achos cleifion trawsffiniol.

Fel rhan o'r adolygiad, dylai'r Bwrdd Iechyd gynnal archwiliad o sampl a ddewiswyd ar hap o gleifion a ryddhawyd o'r AMU yn y 6 mis diwethaf i ganfod a oedd y presgripsiynau a ddarparwyd ar adeg rhyddhau wedi bod yn destun gwiriadau priodol yn unol â safonau mewnol ac allanol perthnasol. Dylai'r Bwrdd Iechyd gyflwyno canlyniad yr adolygiad a'r archwiliad i'r Ombwdsmon ynghyd â chynllun gweithredu i roi sylw i unrhyw achosion o ddiffyg cydymffurfiaeth a ganfuwyd yn ystod yr archwiliad.

92. Rwyf yn falch o nodi bod **y Bwrdd Iechyd** yn ei sylwadau ar y drafft o'r adroddiad hwn wedi cytuno i weithredu'r argymhellion hyn.

Michelle Morris

5 Mehefin 2026

Michelle Morris

Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombwdsmon

Ombwdsmon Gwasanaethau Cyhoeddus Cymru
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Ffôn: 0300 790 0203
Gwefan: www.ombwdsmon.cymru
Dilynwch ni ar X: @ombwdsmon.cymru



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The investigation of a complaint
against
Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202501841

Contents	Page
Introduction	1
Summary	2
The complaint	5
Investigation	5
Relevant standards and guidance	5
The background events	8
Mrs P's evidence	11
The Health Board's evidence	12
Professional advice	14
Analysis and conclusions	23
Recommendations	30

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and others have been changed as well.

Summary

Mrs P complained about care provided by the Health Board to her late husband, Mr P, at Wrexham Maelor Hospital in March 2024. The investigation considered whether it was clinically appropriate to prescribe Sevredol (morphine sulphate) to Mr P and whether Mr P and his family were provided with sufficient information and support to minimise the safety risks associated with the prescription of Sevredol.

Both complaints were **upheld**. The investigation found that Mr P was mistakenly issued with morphine sulphate on leaving hospital. The prescribing doctor had prescribed the medication for use in hospital only and did so believing, wrongly, that Mr P had been taking the medication before his admission. There was a series of failures to carry out expected checks which would have identified this error. This was compounded by poor communication by the medical and pharmacy teams. The result was that Mr P was given a controlled medication without being made aware of the risks and without any guidance on how to take it safely.

Tragically, Mr P died of a morphine overdose 2 days later. The investigation found that supplying Mr P with morphine sulphate in error without appropriate advice and guidance significantly increased the risk that he would suffer an accidental overdose. This was an extremely serious injustice to Mr P and to his family.

The Ombudsman was also concerned that the Health Board had missed opportunities to acknowledge and address the seriousness of the communication and process failings which led to the prescription error. This was not in keeping with the Health Board's obligations under the Duty of Candour which requires NHS Wales organisations to be open with service users when things go wrong.

The Ombudsman noted that this is the second successive public interest report she has issued involving the Health Board which has identified shortcomings in relation to the Duty of Candour. The Ombudsman said she would expect the Health Board to take this opportunity to ensure that the requirements and spirit of the Duty of Candour are fully embedded in the culture and daily practice of its clinical and complaints teams.

The Health Board agreed to the Ombudsman's recommendations to:

- a) Apologise to Mrs P for the failings identified in this report, and in particular, for issuing Mr P with Sevredol without ensuring that it was safe and failing to provide him with appropriate advice about the risks of its use.
- b) Make a financial redress payment of £2000 to Mrs P to reflect the injustices caused to Mr P and his family by these failings.
- c) Share the learning points from this case (in fully anonymised form) with all medical and pharmacy staff and remind them of their responsibilities in accordance with the NICE controlled drugs guidance, and the Health Board's Medicines Policy. This communication should highlight the importance of documenting the clinical rationale for prescriptions, and emphasise that the safe prescription of medication should be prioritised, and that clinicians should consider delaying discharge or not providing medications if necessary to achieve this. It should also urge them to make every effort to counsel patients prior to discharge about their medicines, prioritising those patients on high-risk medicines like opioids and anticoagulants and those prescribed new medicines.
- d) Share this report with the Consultant for the purposes of reflection as part of continual professional development and for consideration at their next annual appraisal.
- e) Share this report with the Health Board's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.
- f) Share this report with the Health Board's Quality and Patient Safety and Quality and Risk Committees to consider my findings and include its learning from these recommendations in its Annual Duty of Candour report.

g) Carry out a review of process and practice within the medical and pharmacy teams to address all the failings identified in this report. The review should be coordinated with the involvement of senior management and the medical directors within the relevant directorates. It should:

- Investigate and provide assurance that all prescriptions are subject to all appropriate checks and enquiries by the prescriber and by the pharmacist on the ward (see paragraph 43), and where this is not possible that the same steps are carried out by a pharmacist prior to discharge.
- Identify actions to improve multiprofessional working and communication between the medical and pharmacy teams.
- Consider whether the process for completing an interim discharge summary should be amended to include information about whether the prescription was new, or pre admission.
- Identify and address barriers to clinicians accessing information about prescriptions from GP practices in England.
- Consider whether DMRs are being used where appropriate, and to address any barriers to their use for cross-border patients.

As part of the review, the Health Board should conduct an audit of randomly selected discharges from the AMU from the past 6 months to determine whether the prescriptions provided on discharge were subject to appropriate checks in accordance with relevant internal and external standards. The Health Board should provide the Ombudsman with the outcome of the review and the audit along with an action plan to address any instances of non-compliance identified during the audit.

The complaint

1. Mrs P complained about care provided by Betsi Cadwaladr University Health Board (“the Health Board”) to her late husband, Mr P, at Wrexham Maelor Hospital (“the Hospital”) in March 2024. The investigation considered whether:

- it was clinically appropriate to prescribe Sevredol (morphine sulphate) to Mr P
- Mr P and his family were provided with sufficient information and support to minimise the safety risks associated with the prescription of Sevredol.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mrs P. They also obtained professional advice from 2 professional advisers, Dr Salim Cheeroth, a consultant in acute and geriatric medicine (“the General Physician Adviser”) and Ms Dianne Burnett a clinical pharmacist (“the Pharmacist Adviser”).

3. Both Mrs P and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant standards and guidance

4. The investigation considered the following guidance issued by the General Medical Council (“the GMC”):

- The GMC “Good practice in proposing, prescribing, providing and managing medicines and devices”, last revised March 2022 (“the GMC Prescription Guidance”). This states at paragraph 26 that clinicians must not prescribe medicines if they do not have sufficient information about the patient’s health. It also states that clinicians must consider whether the information they have is sufficient and reliable enough to enable them to provide safe care. They should consider

whether they have access to the patient's medical records or other reliable information about their health and other treatments they are receiving. With reference to the prescription of controlled medications, it states at paragraph 59: "If you don't have access to relevant information from the patient's medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important".

- The GMC "Good Medical Practice", 2024 ("the GMC Good Practice Guidance") (paragraphs 69-71), "Recording your work clearly, accurately, and legibly". This outlines the requirements for clear and accurate records and provides guidance about the level of detail that should be included in a patient's records.

5. The investigation considered the following guidance issued by the National Institute for Health and Care Excellence (NICE):

- NICE Clinical Guideline CG150 "Headaches in over 12s: diagnosis and management", 2012 ("the NICE Headaches Guidance").
- NICE "Clinical Knowledge Summary for Migraine" ("the NICE Migraine CKS"), last revised August 2025.
- NICE National Guideline NG46 "Controlled drugs: safe use and management", 2016 ("the NICE controlled drugs guidance").
- NICE Clinical Guideline NG215 "Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults" ("the NICE dependence-forming medicines guidance").

6. The investigation also considered:

- The British National Formulary (“the BNF”) guidance for morphine (“the BNF Morphine Guidance”). This advises clinicians to “counsel patients and their carers on the risks of tolerance and potentially fatal unintentional overdose, as well as signs and symptoms of overdose”.
- The Health Board’s Medicines policy (2019, version 2.12). This states: “prescribers have a responsibility to monitor and ensure that the medicines they have prescribed have been reviewed. Prescribers should refer to the patient’s existing prescriptions/supplementary charts and the patient’s available records (e.g Individual Health Record – which contains details of GP Practice and current medications – and secondary care records) before prescribing or amending a prescription...The prescriber should provide counselling for the patient about important side effects and precautions, including any need for ongoing monitoring, which if needed should be agreed between primary and secondary care clinicians.” It also states that a pharmacist should clinically check all discharge prescriptions to ensure they are safe and appropriate.
- The All Wales Pharmacological Management of Pain Guidance (2023)
- The All-Wales Multidisciplinary medicines reconciliation policy (retired in 2025)
- The General Pharmaceutical Council “Standards for pharmacy professionals”, May 2017 (“the GPhC Standards”). These apply to pharmacy technicians and pharmacists and apply in whatever setting a patient receives care.

7. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that “being open with service users and their representatives when things go wrong in their care is the right thing to do”. This is in addition to any professional duty of candour a

healthcare professional will be subject to under their own professional practice regimes and specifically applies when a healthcare provider is responding to complaints about a service.

8. My thematic report, “Groundhog Day 2: An opportunity for cultural change in complaint handling?”, June 2023 (“the Thematic Report”). The report highlighted instances where clear evidence of service failures had not been identified by public bodies during complaint investigations, indicating a lack of openness and candour. It also identified a recurring lack of objective review of clinical care and treatment. It noted that NHS bodies very rarely obtain independent medical advice to assist complaint investigations. This option is available to them under the NHS complaints procedure.

The background events

9. Mr P suffered a stroke in **2022**. He was subsequently made redundant and went on to experience anxiety and depression. He had also developed post-stroke fatigue and chronic headaches (he had previously been seen by his GP for migraine in 2010).

10. On 16 February **2024** Mr P was admitted to the Hospital with symptoms including anxiety, sweating and hallucinations. It was noted that he had suddenly stopped drinking 4 days previously after a period of 2-3 months of covertly drinking around half a bottle of vodka a day. He was diagnosed with alcohol withdrawal and treated with detoxifying medications before being discharged on 23 February.

11. On 5 March Mrs P took Mr P to the emergency department (“the ED”) at the Hospital. He was suffering hallucinations and confusion in connection with alcohol withdrawal symptoms. On admission the pharmacy team carried out a reconciliation of Mr P’s current medications (where a patient’s medication regime is reviewed and checked to ensure that clinicians have an accurate list of their current medications and to identify any discrepancies). As part of this process a member of the pharmacy team contacted Mr P’s GP practice in England.

12. The medication reconciliation confirmed that at the time of the admission on 5 March Mr P was taking the following medications: warfarin, omeprazole, atorvastatin, propranolol and sertraline. It was noted that a prescription of thiamine had been initiated in the Hospital, and that Mr P had been buying over-the-counter paracetamol. There was no reference to Sevredol or any other opiate medication such as Zomorph (morphine sulphate in capsule form). (Mr P's GP records dating back to March 2021 contain no references to his having been prescribed opiate medications).

13. During the admission, Mr P was seen by alcohol liaison nurses ("ALNs") and he received further detoxifying medication. On 7 March Mr P was transferred to the Acute Medical Unit Short Stay ward ("the AMU") where he was under the care of a consultant nephrologist (a doctor specialising in kidney diseases and related conditions - "the Consultant"). On 9 March a nurse recorded that Mr P had complained of a headache and he had been given paracetamol with "moderate effect". The following day it was noted that Mr P had reported ongoing headaches and nausea since his admission.

14. On 13 March Mr P was reviewed by an ALN. It was noted that he had completed the alcohol withdrawal regime and was feeling well with no problems reported. He was discharged from the alcohol liaison service. Mr P was also seen by the Consultant who noted that the aim was to discharge him the following day, after reviews by the psychiatric and physiotherapy teams. A physiotherapy review took place later that day.

15. At around 10:15 on 14 March the Consultant saw Mr P on a ward round. He noted that Mr P was awaiting review by the psychiatric liaison team with a view to being discharged home later that day.

16. Following the ward round a prescription for morphine sulphate was added to Mr P's medication chart. The clinical indication was recorded on the chart as "migraine" and the dose was 10mg 4 hourly PRN (pro re nata - as needed). The chart shows that no doses were administered. The clinical records contain no further reference to the clinical reasoning for this prescription.

17. Mr P contacted his GP practice online to request medication to help him sleep in hospital. A representative of the GP practice responded that it could not provide medication to him while he was an inpatient at the Hospital.

18. At 17:00 the psychiatric liaison nurse noted that Mr P appeared to be struggling with past grief, but he had not reported any issues with his mood or suicidal ideation and there was no evidence of any significant mental illness. It was noted that Mr P had an appointment for private counselling on 18 March which he had arranged himself. Mr P was discharged home later that evening. The medication list on the discharge notification included a prescription for Sevredol (10x 10mg tablets for use when required). The medication was recorded as a pre-admission drug which was to be continued.

19. On 16 March Mr P was found unconscious at home. Mrs P called 999 and stated that she was concerned that Mr P had taken an accidental overdose of morphine. Paramedics attended at 06:03 and attempted cardiopulmonary resuscitation, but sadly Mr P was pronounced dead shortly afterwards. The paramedics noted that there was no evidence of any empty packets or of medication at the scene.

20. A post mortem report stated that toxicology analysis had found morphine levels in Mr P's blood which, in a person who is not tolerant to morphine, would be consistent with fatal morphine toxicity (Mr P had 160 ng/mL of morphine in his blood – any level above 50ng/mL can be fatal). It was noted that there was no evidence of a planned suicide. It also noted that he had previously taken Zomorph, but it was not clear where this information was obtained and no further detail was given.

21. In July a coroner's inquest recorded a finding of death by misadventure.

22. On 8 September Mrs P submitted a formal complaint to the Health Board. On 20 September, the Health Board held a Rapid Review ("the Rapid Review" - a meeting that takes place when a concern has been raised which involves the death of a patient). The Rapid Review was attended by the investigating officer, the Clinical Director for Medicine and Community, the Matron for Emergency Care, a Patient Safety Lead Pharmacist and a Clinical Governance Facilitator.

Mrs P's evidence

23. Mrs P said that after her husband suffered a stroke, he struggled enormously to manage his health. She said he suffered post stroke fatigue and struggled with sickness and with eating. He was diagnosed with a blood condition which required daily anticoagulant (blood thinning) medication and he developed stomach ulcers, anxiety and depression. She said that his conditions escalated, one triggering another, symptoms overlapped, and one illness could easily mask another; he underwent numerous investigations under several consultants and had numerous GP appointments and hospital attendances. She said this constant cycle caused him significant frustration.

24. Mrs P said that, tragically, in his attempt to manage the overwhelming impact of his illnesses, her husband secretly turned to alcohol and medication as coping mechanisms. These behaviours were hidden beneath the complexity of his other conditions and were not recognised by her or by the medical professionals involved in his care.

25. Mrs P said she trusted that Mr P was in a safe environment, receiving appropriate care from professionals who were fully aware of his medical history, vulnerabilities, and the risks involved, but that trust was misplaced. She said that she had no idea that Mr P had been prescribed Sevredol on discharge from the Hospital. She said that Mr P did not have a copy of the discharge summary on discharge, and he did not tell her about the morphine medication.

26. Mrs P said she could not understand how the Consultant could have prescribed the medication simply on the basis that Mr P asked for it, without carrying out any checks that what he was saying was reliable. She questioned whether it was appropriate to prescribe the drug given Mr P's history of alcohol addiction, and of confusion and hallucinations. She said it was possible his headaches were caused by the withdrawal, and that there should have been other less risky medications he could have been prescribed. She said she feels completely failed by the very professionals she should have been able to trust: those her husband confided in and relied upon for help.

27. Mrs P said that she did not think her husband's addiction problems were fully addressed. She felt that after being treated for withdrawal Mr P was looking for replacements for the alcohol, and that this was why he had asked the Consultant for morphine. She said he had asked his GP for medication but had been refused.

28. Mrs P said that Mr P had not been given any guidance as to how to take morphine sulphate safely. She said she felt it was as though her husband had been sent home from hospital with a loaded gun.

29. Mrs P said she had found Mr P with an empty packet of Zomorph on the morning of 15 March, which she said was an old out of date prescription for her father she was not aware he had. She said that the only other time Mr P had been prescribed morphine was for a foot injury in 2006. She said that when Mr P went to bed that evening, she was unaware what medication he had taken. She said he was fully responsive and she was unaware that he was in any danger.

The Health Board's evidence

30. The Health Board said in response to the investigation that the Consultant had prescribed Mr P a relatively small dose of Sevredol, largely for inpatient use, based on Mr P's explanation that he was taking it for his headaches. It said that, on that basis, the prescription was clinically appropriate. It said that Mr P had not asked to take the medication home and if Mr P had asked for this, the Consultant would have questioned this.

31. The Health Board said that it appeared from a handwritten crib sheet completed on 8 March that the pharmacy team had confirmed Mr P's regular medication with the GP in England by email. It said that this documentation showed that Mr P was not previously prescribed Sevredol or any other morphine preparation from his GP and he was not prescribed it by the admitting doctor. It said the crib sheet was not printed and put on the file because it had confirmed a drug history that was already documented. It said that a resident doctor in the Consultant's team prepared Mr P's discharge prescriptions with 10 x 10mg tablets of Sevredol for him to take home and noted that this was a pre-admission drug based on the information provided by Mr P.

32. The Health Board said that the interim discharge sheet provided by the Consultant's team to the pharmacy team was a standard form which did not include a section for classifying a medication as "pre-admission drug continued" or "hospital initiated". It said this was in line with standard practice to improve the time taken to prepare medications for discharge and to enable the doctor to prepare the discharge letter when time allows. It said that the discharge letter was prepared on 18 March so it would likely not have been clear to the pharmacist whether the prescription was newly prescribed or restarted. However, it said that it was not necessary to know this information to deem the prescription clinically appropriate. It said that during the Rapid Review the Patient Safety Lead Pharmacist had advised that, even if the medication had been considered a new prescription, Mr P would still have been prescribed the same quantity of medication.

33. The Health Board provided a statement by the Consultant. In it he said that he had formed a good doctor-patient relationship with Mr P. He said that Mr P had confided in him about a lot of his problems, and he had reassured him that he would do his best to help him. The Consultant said that on 14 March he had finished seeing Mr P on the ward round and was about to start seeing the next patient when Mr P called him back and asked if he could have some Sevredol, that he usually took for his headaches. He said that he had no reason to doubt Mr P as he seemed to have knowledge of the drug, given that he had asked for it by its brand name.

34. The Consultant said he had prescribed a small dose largely for inpatient use, and that the dose was not sufficient to pose a risk of addiction. He said that Mr P did not ask for some to take home and that if he had this would have raised questions and he would have been very unlikely to have prescribed it on that basis alone. He said "I did not feel at the time, this small dose of Sevredol was an unsafe prescription. If Mr P had asked for some "to take home", would I have prescribed it, no I would not. If I knew he was not on it pre-admission, no, he would not have had it as I would have started with simple analgesia. The prescription was for as and when use at a low dose in hospital." The Health Board said that it was regretful Mr P was given Sevredol to take home by the discharging doctor, even though the Consultant's intention was to prescribe the medication to take as and when at a low dose in the Hospital.

35. The Health Board said that Mrs P was not informed about the prescription as Mr P did not lack mental capacity and it would not be the usual practice to routinely inform families in those circumstances. It said a copy of the discharge prescription would have been available to Mrs P to read (Mrs P said Mr P did not receive a copy). The Health Board acknowledged that Mr P did not receive counselling about the risks of morphine based medications in accordance with the BNF Morphine Guidance. It said this was based on the belief that Mr P had been taking the medication prior to the admission.

Professional advice

36. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. The Ombudsman determines whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

The Pharmacist Adviser

37. The Adviser said it was not clinically appropriate and safe for the pharmacy team to issue the Sevredol prescription to Mr P on 14 March. She said that the pharmacy team did not have enough information to make a safe supply in terms of the clinical rationale of the treatment and the pharmaceutical elements of the medicine.

38. The Adviser said that it was the pharmacy team's responsibility to verify the clinical appropriateness of a patient's prescribed medication. She explained that on admission the pharmacy team should within 24 hours carry out a medicines reconciliation with reference to at least 2 reliable sources of information. The pharmacist should then review the information collected and address any problems identified before confirming that the reconciliation process was complete. In Mr P's case, this was confirmed on 12 March.

39. The Adviser said that the fact that the reconciliation process had not identified any reference to Sevredol having been previously prescribed should have prompted the pharmacy team to query the appropriateness of

the request on 14 March. She said that the absence of any documentation of the rationale for providing a strong opioid for the treatment of migraine should also have raised a flag with the pharmacy team which should have triggered an attempt to obtain further information from the Consultant's team.

40. The Adviser noted that there was no reference in the Hospital's clinical records to Mr P having a history of migraine. On admission, Mr P had denied recent headaches. She said that in her experience the use of opioids, and particularly morphine, as a single agent for the management of headaches or migraine did not follow current practice. She said that there would be an expectation to see some history of weaker opioid use like codeine together with paracetamol. She noted that the All Wales Pharmacological Management of Pain Guidelines state that opioid therapy should be reserved for symptoms that are persistent despite first line treatments. In addition, she noted that the NICE Migraine CKS recommended simple analgesia (medication used to relieve pain) initially. Further, she noted that the NICE Headaches Guidance states that opioids should not be used for the acute treatment of tension type headache, cluster headache or migraine.

41. The Adviser said that she had not seen any evidence that Mr P had previously used analgesia for headaches or migraine above and beyond the use of paracetamol he bought over-the-counter. She said that, taking this into account and that opioids are not the usual treatment for migraine or headaches, the pharmacy team should have investigated the clinical rationale for the request. The Adviser said that this would have been the case regardless of whether Sevredol was previously prescribed or if it was being requested as a new intervention. The Adviser noted that there were no clinically significant interactions between Sevredol and the other medications Mr P was prescribed and there was nothing in his physiology that would have increased the risk of morphine toxicity.

42. The Adviser said that it appeared that the pharmacy team had failed to carry out a number of expected checks before issuing the prescription. Firstly, she said that a pharmacist should review the medication requested on the ward and sign the pharmacist clinical check box on the medication chart. However, the check box on the relevant chart was not signed. She said the purpose of the review was to ensure that the prescription was

clinically appropriate and should involve checking the patient notes and drug history, checking with the prescriber, and checking with the GP practice or community pharmacy.

43. The Adviser said that for this prescription the ward pharmacist would also normally check the normal treatment of chronic headaches/migraine, check the patient's bloods and check potential interactions with other medications. As a controlled drug was involved, the check would also be expected to include steps set out in the NICE controlled drugs guidance. These include:

- document clearly the indication and regimen for the controlled drug in the person's care record
- discuss with the person the arrangements for reviewing and monitoring treatment
- be prepared to discuss the prescribing decision with other health professionals if further information is requested about the prescription
- check that the prescription is appropriate for the patient's current clinical needs and to ensure that the reason for the prescription has been clearly recorded in the records.

44. The Adviser noted that, based on the medical records, the drug chart was probably completed by the Consultant's team at around 10:15 on 14 March. The discharge prescription was entered into the pharmacy team's prescription tracking system at 16:16. She said there were a number of common operational reasons which could explain why the pharmacist check box remained unsigned prior to the discharge prescription being assembled. For example, it could have been due to a lack of availability of a pharmacist to cover the ward.

45. The Adviser said that before a discharge prescription is processed and released to the patient to take home, a pharmacist is required to carry out a clinical review of the medicines. The Adviser said that the fact that the check box on the medication chart had not been signed indicated that

the required checks outlined in paragraph 43 had not been carried out on the ward. Accordingly, the pharmacist reviewing the discharge medications should have carried out these checks.

46. The Adviser said that the dose and formulation (tablets, capsule, liquid or modified release) should have been confirmed with the prescriber, the GP practice or the patient. She said that the formulation must always be stated when prescribing controlled drugs for outpatients or discharge prescriptions, but that this did not apply for prescriptions for inpatient use only. In this case the medication chart noted the route of administration (oral) but not the form. The Adviser noted that the 4 hourly dosage had been endorsed on the chart in green pen. She said that she assumed that this had been done by a pharmacy technician on the basis that a pharmacist reviewing the chart would likely have signed the checkbox.

47. The Adviser explained that morphine sulphate is available as oral liquid (Oramorph liquid 10 mg/5 ml), immediate release tablets (Sevredol 10 mg tablets) and modified release preparations (Zomorph 10 mg capsules). She said that most prescribing of morphine is done by prescribing the brand because of the safety implications of supplying a formulation with different release characteristics than what the patient is used to. She noted that the Health Board's Medicines policy clearly states that prescribing by brand is necessary when there are differences in bioavailability (the rate at which the active ingredient of a medication is absorbed into the bloodstream) between brands of the same medicine. As the request was listed in the "when required" section of the medication chart with a 4 hourly dose, it would have been reasonable for the pharmacy team to assume that the prescriber intended for an immediate release formulation to be supplied. However, the drug chart gave no indication of whether tablets or liquid should be supplied.

48. The Adviser said it was not clear how the request for morphine sulphate 10mg on the medication chart was transcribed by the pharmacy team into the issue of Sevredol tablets when the chart was not endorsed with the brand or formulation. She said that given that this information was not recorded anywhere in the clinical notes, a conversation must have taken place between the individual who compiled the discharge prescription and a member of the Consultant's team, or Mr P, to confirm the brand. The

Adviser said that at this point, this individual within the pharmacy team should have asked for more information to provide assurance about the appropriateness of the prescription.

49. The Adviser said that the pharmacy team would also have been expected to confirm when Mr P had previously received Sevredol and if he had a supply at home. This was important to avoid the risk of patients hoarding medication, which is a safety risk and a waste of supplies. Also, given that dispensing controlled drugs can delay discharge due to the extra checks required, it was important to check that the controlled drug was really necessary. She said that a call to the GP practice would have been helpful, and that this should have been possible despite the fact that the information from the GP practice in England was not accessible through the Welsh Clinical Portal (an electronic patient record system used by the NHS in Wales). She said that these checks would have revealed that Sevredol had not previously been prescribed, which would have raised questions about the appropriateness of the prescription.

50. The Adviser said that as the discharge was being prepared towards the end of the working day, there may have been pressure to process the discharge swiftly. She said that in her view it would have been safer to discharge Mr P without supplying the morphine until appropriate checks had been completed. Paracetamol could have been supplied instead.

51. The Adviser said that both the medical team and the pharmacy team worked in isolation from each other which led to assumptions being made about Mr P and his medicines. Insufficient checks were carried out and as a result a medicine was supplied that was not safe. She said that in the interests of service improvement the pharmacy team should reflect on Standards 2 and 5 of the GPhC Standards.

52. The Adviser explained that Standard 2 describes how pharmacy professionals must work in partnership with others as a person's health, safety and wellbeing are dependent on these partnerships where everyone is contributing towards providing the person with the care they need. This includes other healthcare professionals and teams, carers and relatives. The Adviser said that it would be hugely beneficial for the pharmacy team and the Consultant's team to work together on the ward so that the expertise can be utilised from both professions to achieve an improved patient

experience. She said that a multidisciplinary approach would have been an excellent opportunity to learn about the therapeutic management of headache.

53. The Adviser noted that Standard 5 requires that pharmacy professionals must use their judgment to deliver safe and effective care. In meeting this standard, pharmacy professionals must ensure that they have the information they need to provide appropriate care. In Mr P's case the pharmacy team failed to take steps to obtain the information they needed to ensure the safe supply of Sevredol.

54. The Adviser said that every attempt should be made to speak to a patient about their medicines before discharge. She noted that counselling did not take place on the assumption that Mr P was already on the medication. However, she noted that the discharge prescription included a new medication, thiamine, and while warfarin was a pre-admission drug, Mr P would have needed to know that the dose had not changed. The Adviser said that the pharmacy team should have spoken Mr P to discuss these points.

55. Finally the Adviser noted that the All-Wales Multidisciplinary medicines reconciliation policy recommends that when patients are discharged from hospital the use of a Discharge Medicines Review ("DMR") service should be considered as a method of communicating any medicines reconciliation issues for appropriate patients. She said that in primary care healthcare professionals completing medicines reconciliation must do this for all people who have been discharged from hospital or another setting. Medicines reconciliation should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within one week of the GP practice being informed that the patient is being discharged. However, the Adviser noted that Mr P was resident in England and while there was an equivalent Discharge Medicines Service ("DMS") which took referrals from NHS Trusts in England, it was not clear how a health board from Wales could refer a patient.

The General Physician Adviser

56. The Adviser was asked to consider whether the medical team was acting within the range of appropriate care when prescribing morphine sulphate to Mr P. The Adviser said that it was challenging to comment on the appropriateness of the prescription given that the clinical reasoning was not documented at the time. He said he could not find any documentation concerning the Consultant's choice to prescribe morphine, the reasoning for the morphine prescription, his discussion with the patient, the dosage schedule for the morphine, the intended length of the prescription, or if it was intended to be continued after discharge, that is, discharge with morphine to take home.

57. The Adviser noted that the GMC Good Practice Guidance (paragraphs 69-71) emphasises the necessity for physicians to keep precise records of their activities, ensuring that there is a sufficient level of detail that includes clinical findings, investigations, and treatments provided or administered. The Adviser said that, taking this into account, the Consultant and his team did not meet the expected standard for documenting his clinical decision making. He noted that documentation was often completed by a resident (junior) doctor whose skills in documenting a consultation were very variable, and time limitations typically prevented consultants from reviewing everything a resident doctor recorded. Nevertheless in such time-restricted situations, it was crucial to identify the most significant elements that needed to be documented, and in this instance, that did not occur.

58. The Adviser noted that the indication given for the prescription on the medication chart was migraine and that on the same page it was recorded that Mr P was prescribed paracetamol as required, and that he had needed this on 6 occasions during the admission, including on the morning of 14 March. The Adviser said that while there was no mention in the record of the Consultant's ward round on 14 March of Mr P complaining of pain, it was reasonable to conclude that headaches were an ongoing issue, taking into account the report on 10 March of ongoing headaches since admission. There was no reference in the admission notes of Mr P being on morphine on admission, and no reference to a history of migraine.

59. The Adviser noted that the NICE Migraine CKS and the NICE Headaches Guidance stated that opiates should not be used for migraine or for headaches following a stroke, regardless of the cause. However, he said that in his experience, it was typical in practice, where medications had proven beneficial in the community to continue administering these in hospital.

60. The Adviser said that, if it was assumed that the Consultant understood that Mr P had been taking morphine sulphate in the community prior to the admission, and that this had provided relief, it was reasonable to prescribe this for in-patient use for the persistent headaches he had experienced during the admission. Even if the Consultant had been aware that Mr P had not been taking morphine prior to the admission, the prescription of morphine for inpatient use may have been appropriate if it was felt that the morphine was required to get on top of the pain.

61. The Adviser said that the checks the Consultant's team carried out before arranging the prescription were not exhaustive but were appropriate on the basis that the prescription of morphine was intended for inpatient use. He said that it appeared that the Consultant did not intend to discharge Mr P with this medication. He said that, if it had been his intention to prescribe this medication for Mr P to take home, even for a short period the Consultant would have been required to act with caution and to consider the checks and precautions set out in the GMC Prescription Guidance, the NICE controlled drugs guidance, the NICE dependence-forming medicines guidance and the BNF Morphine Guidance. This would have included the need to counsel Mr P about the potential dangers of morphine and advise him against prolonged use of the medication.

62. The Adviser said that in these circumstances there would have been an expectation to clarify with Mr P's GP practice if Mr P was taking morphine in the community and, even if he was, to query the wisdom of it and to suggest a plan in the discharge summary to withdraw the morphine in the community.

63. The Adviser said that the NICE dependence-forming medicines guidance recommends that before starting or continuing treatment with an opioid that all suitable management options have been discussed with

and offered to the person. He noted that the guidance states that clinicians should consider whether there are any factors that might increase the person's risk of developing problems associated with dependence, including a history of mental health problems or alcohol misuse, but cautions against withholding medications solely on the basis of one of these. The Adviser noted that Mr P had been reviewed by the alcohol and psychiatry liaison teams.

64. The Adviser said that the GMC Prescription Guidance requires that “before proposing, prescribing or providing medications, treatment or devices, you must consider whether the information you have is sufficient and reliable enough to enable you to provide safe care”. He said that it was reasonable for the Consultant to conclude that he had enough information to make a prescription for use in hospital on the basis that Mr P had told him that he had been taking Sevredol for headaches in the community. He said that the Consultant knew Mr P’s clinical background and was prescribing morphine at an acceptable, as required dose.

65. The Adviser said that the Consultant was not aware that the information Mr P had provided was not reliable. He said that it is usual to accept what a patient tells a clinician as being the truth unless there is good reason to believe a patient is lying. To question the honesty of a patient without reason is time consuming and not practicable and, furthermore, compromises the trust in the doctor-patient relationship. He said that checking the clinical records would not necessarily have indicated that Mr P’s information was unreliable, because records are not always accurate or complete.

66. The Adviser said that medicines for patients to take home are usually written up by resident doctors or pharmacists and checked by pharmacists; they are not routinely checked by consultants. He said that had the Consultant intended to issue the prescription as a new medication, this could still have been regarded as an appropriate prescription, as it was an acceptable starting dose and Mr P was only provided with 10 tablets, which at 10mg every 4 hours as required was only 2 days’ supply. However, the difference for prescribing morphine as a new discharge medication would have been that the Consultant was required to act with caution, and in accordance with the relevant guidance as explained in paragraph 61 above.

67. The Adviser noted that the NICE dependence-forming medicines guidance (paragraph 1.2.3) advises clinicians to “during the first discussion about prescribing, give the person information and advice (in their preferred format) to help them balance the potential benefit of the medicine and other treatment options with the risk of long-term consequences”. The adviser said in this regard it would have been particularly important for Mr P to receive this information. The provision of information to Mr P’s family was of lesser significance because Mr P was not confused. However, if time was permitted, this would be considered a commendable practice.

Analysis and conclusions

68. In reaching my conclusions I have considered the advice that I have received from the Advisers, which I accept. However, the conclusions reached are my own. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

Whether it was clinically appropriate to prescribe Sevredol (morphine sulphate) to Mr P

69. I **uphold** this complaint. In the first instance, it was the responsibility of the Consultant and his team to ensure that the requested prescription was clinically appropriate. Having regard to the General Physician Adviser’s advice, I find that the Consultant and his team failed to document a rationale for the prescription of morphine sulphate. This was contrary to the requirements of the GMC Good Practice Guidance and the guidance documents relating to prescriptions listed in paragraphs 4, 5 and 6. Accordingly there was a failure at the time to demonstrate that the prescription was clinically appropriate.

70. The Consultant said in later statements that the prescription was for in-patient use and not for Mr P to take home on discharge. However, according to the note of the ward round on 14 March the plan was for Mr P to be discharged later that day, subject to a psychiatry review. Given that the Consultant was clearly contemplating Mr P’s imminent discharge, he should have been aware of the need to clearly communicate to his team and the pharmacy team that the requested prescription was not to be given to Mr P to take home. This intention was not recorded in the notes and it is evident that it was not communicated verbally.

71. The General Physician Adviser has explained that the prescription and dose was potentially clinically appropriate for in-patient use, and even as a new medication on discharge, regardless of whether Mr P had been taking it in the community. However, in my view it was clearly clinically inappropriate that Sevredol was issued to Mr P to take home against the Consultant's intentions. This could have been avoided if the rationale for the prescription had been documented and communicated to colleagues at the time. The Health Board's Medicines policy is clear that prescribers have a responsibility to ensure the medicines they have prescribed have been reviewed, and that they should refer to the patient's existing prescriptions in doing so. Mr P's current prescriptions may not have been visible on his electronic record because his GP practice was in England, but there is no indication that the Consultant or his team attempted to check this information. In any event, the records from Mr P's admission included ample information about his medications on admission.

72. The pharmacy team had an equal responsibility to verify that the prescription was appropriate and safe to issue to Mr P. The Consultant said that he would not have prescribed morphine sulphate to Mr P on 14 March if he had been aware that it was not a pre-admission prescription. Instead, he would have started Mr P on a simple analgesia. The pharmacy team had, by 12 March, completed a medicines reconciliation process which confirmed that morphine sulphate was not a pre-admission prescription. I find, with reference to the Pharmacist Adviser's advice, that there were a number of missed opportunities for the pharmacy team to query the prescription with the Consultant's team and to make them aware of this vital information.

73. Firstly, the pharmacy team should have carried out a clinical check of the prescription on the ward; this would have involved checking the patient notes and drug history, checking with the prescriber and checking with the GP practice or the community pharmacy. It would have been particularly important to check the rationale with the prescriber given that opioids are not the usual treatment for migraine or headaches and there was no clinical justification for the prescription in the notes. It is highly likely that even a brief conversation with the prescriber to check the rationale for the prescription would have identified that morphine sulphate was not a pre-admission medication and that the Consultant did not intend for the medication to be issued as a discharge drug.

74. It appears from the records that the medication chart was not checked by a ward pharmacist. The fact that this did not occur meant that it was especially important that the appropriate checks were carried out by the pharmacy team prior to issuing the discharge medications. As a controlled drug had been requested, there was also an expectation to take additional steps to ensure that the prescription of Sevredol was safe (see paragraph 43). Having regard to the Pharmacist Adviser's advice I find that there was a failure to carry out the expected checks before issuing the prescription.

75. The pharmacy team would have been expected in the circumstances, and given that a controlled drug had been requested, to confirm that the patient had previously received Sevredol. The information given by Mr P to the Consultant that Sevredol was a pre-admission medication was not consistent with the medication list confirmed by the reconciliation process. This obvious discrepancy should have been flagged up during the discharge medication review and should have prompted the pharmacy team to check when the last prescription had been issued. I agree with the Pharmacist Adviser that it should have been possible to call the GP practice or community pharmacy to confirm this. If this was not possible due to the time of day, Mr P should have been discharged without the prescription or the discharge should have been delayed.

76. The Health Board said that the pharmacy team would not have known from the interim discharge sheet provided by the medical team whether the medication was "pre-admission drug continued" or "hospital initiated" but that it was not necessary to know this information in order to verify that the prescription was clinically appropriate. Its Rapid Review found that even if the prescription had been categorised as a new medication, Mr P would have been supplied with the same quantity. This ignores the fact that the Consultant did not request the medication as a new prescription and did not intend for it to be issued to Mr P on discharge: on that basis, it was clearly not clinically appropriate to issue a medication which was contrary to the intention of the prescriber.

77. While the desire to reduce the administrative burden on clinicians is understandable, Mr P's case illustrates the significance of not requiring prescribers to indicate the status of medications (pre-admission or new)

on the interim discharge sheet. If this information had been included in the interim request the pharmacy team would have been alerted to the fact that the prescription was based on the Consultant's incorrect understanding that Mr P had been taking morphine in the community. By the time the category had been recorded on the final discharge letter on 18 March Mr P had been discharged and had sadly died. It seems to me that it is particularly important that the pharmacy team is aware of the intended category at the point of discharge when they are issuing controlled drugs.

78. I agree with the Pharmacist Adviser that it is likely that a member of the pharmacy team must have spoken to a member of the Consultant's team or with Mr P to confirm the brand name and formulation for the prescription as these had not been indicated on the medication chart (this was itself a breach of the Health Board's Medicines policy). In doing so, they missed a key opportunity to gather more information about the nature and purpose of the prescription. At the point of discharge the pharmacy team could not have been assured that the prescription of Sevredol was safe or appropriate. This was a significant service failure.

79. Having regard to the Pharmacist Adviser's advice, I find that the mistaken issue of Sevredol to Mr P was the result of a failure by the medical team and the pharmacy teams to work together adequately. If appropriate multidisciplinary cooperation and communication had taken place, it is likely that the prescription would not have been issued. Instead it was mistakenly issued to Mr P, against the prescriber's intentions and without the benefit of a cautious and detailed consideration of the risks, as required by the relevant guidance. It also meant that Mr P did not benefit from the advice and information that would normally be given to a patient receiving a new prescription of controlled drugs. These were serious injustices to Mr P.

80. It is clear to me that in prescribing morphine sulphate the Consultant was strongly motivated to do as much as he could to help Mr P. He had built a good rapport with Mr P and felt he had no reason to doubt that Mr P had been prescribed Sevredol recently and had been taking it with good effect before he was admitted to hospital. I agree that the doctor-patient relationship is built on trust and that the Consultant was entitled to believe what he was told. However, on occasions

information provided by patients will be unreliable or inaccurate. That is why relevant guidance and standards for medical and pharmaceutical professionals emphasise the importance of appropriate documentation, communication and multidisciplinary working to reduce the risk of harm to patients arising from the use of prescribed medications, particularly in relation to controlled medications such as morphine. It is very concerning that the systems of medication reviews in the Health Board's pharmacy team, which should have provided a safeguard, repeatedly failed in Mr P's case.

81. Mrs P said she felt as if her husband was handed a loaded gun. Her comments are understandable. It was not safe to provide Mr P with Sevredol, even taking into account that it was only a 2 day supply at a relatively low dose. In a person who was not tolerant to morphine, there was a potential risk of accidental morphine toxicity, especially where the medication was provided without appropriate advice about how to take it safely.

82. It is not known whether the morphine in Mr P's blood at the time of his death was from the Sevredol provided by the Hospital, from an old supply of Zomorph, or a combination of both. It is not possible on the available evidence to conclude that Mr P's overdose would not have occurred if the Sevredol had not been issued. However, it is relevant to note that the only confirmed supply of morphine in Mr P's possession at the time was the Sevredol issued by the Hospital. I also note that there is no evidence that he had taken morphine prior to his admission, so it appears highly likely that he would not have been tolerant to morphine. It is reasonable in my view to conclude that supplying Mr P with morphine sulphate in error and without appropriate advice and guidance significantly increased the risk that he would suffer an accidental overdose. This was an extremely serious injustice to Mr P and to his family. Taking into account the severity of these injustices, I consider that it is appropriate to recommend a significant financial redress payment to Mrs P.

Whether Mr P and his family were provided with sufficient information and support to minimise the safety risks associated with the prescription of Sevredol

83. I **uphold** this complaint. In effect, the Sevredol was issued to Mr P as a new prescription, and if it had been intended as such there would, according to the BNF Morphine Guidance, have been an expectation to advise Mr P “on the risks of tolerance and potentially fatal unintentional overdose, as well as signs and symptoms of overdose”. The Health Board acknowledged that there was a failure to counsel Mr P on these risks. It said that this did not happen because it was thought, wrongly, that he had been taking morphine sulphate prior to admission. As I explained above, I consider that it would only have taken basic checks by the pharmacy team or a brief conversation between the pharmacy and medical teams to reveal that this assumption was wrong. The failure to do so led to the injustices I have described above.

84. I accept the Consultant Physician Adviser’s advice that clinicians would not have been expected to inform Mrs P about the prescription, given that Mr P was not confused at the time of discharge. I also note his advice that this would have been commendable practice. In my view, a more considered approach to discharge planning could have involved seeking input from Mrs P, particularly given the history of concerns about substance abuse and covert consumption of alcohol. The Health Board said that Mrs P would have been able to read the discharge summary. This ignored the fact that the discharge summary was not completed until after Mr P’s death.

85. Very sadly, Mr P’s case illustrates the reality of the risks associated with morphine sulphate. It also underscores the importance of good communication between pharmacy and medical teams and of ensuring that processes for prescribing and reviewing medications prior to discharge are robust. It was understandable that once Mr P had been deemed fit for discharge, there would have been an expectation for staff to work to arrange this at the earliest opportunity. The priority, however, should always be to ensure the safety of individual patients by carrying out the necessary checks before issuing medications on discharge. It appears that the desire to arrange a prompt discharge may have been a factor in clinicians paying insufficient attention to the safety of Mr P’s Sevredol prescription. Given

that the Health Board is likely to continue to face ongoing, and occasionally extreme, service pressures, I am concerned that there is a risk similar mistakes could be repeated.

86. It is concerning that while the Health Board has acknowledged that the prescription was issued against the intention of the prescriber, it has maintained that the prescription was appropriate. In my view the Health Board has not properly acknowledged or addressed the seriousness of the communication and process failings which led to this error. I consider that the severity of the failings in Mr P's case are such that they raise wider concerns about the adequacy of the Health Board's process and practice in relation to ensuring safe prescribing on discharge. There is clearly a potential for ongoing risk to patient safety, particularly where controlled medications are involved. I am issuing this report as a public interest report to provide the opportunity for the Health Board to demonstrate publicly its commitment to learn lessons from Mr P's case and to provide reassurance that the failings identified in this report will not happen again. I also consider it is necessary to encourage wider learning from this case among prescribers and pharmacy teams in other parts of the NHS in Wales.

87. Finally, while complaint handling was not one of the heads of complaint I investigated, in light of the information that has become available during this investigation, I must address this. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. I consider that the Health Board's response to Mrs P fell well short of what the duty promotes and is intended to achieve.

88. The Health Board's complaints investigation gathered evidence that plainly showed that Mr P had been issued a controlled drug to take home against the intention of the prescribing doctor, and that this was the result of a series of failures in the medical and pharmacy teams. The fact that these failings were not identified by the Rapid Review or by the Health Board's complaints investigation indicates that Mrs P's complaint was not subject to a sufficiently robust or objective review. In particular, I consider that there was a missed opportunity to obtain independent medical advice. This would very likely have identified the failings during the Health Board's investigation. These complaint handling shortcomings are all the more disappointing, given that these issues were highlighted as key learning points in the Thematic Report.

89. This is the second successive public interest report I have issued involving the Health Board which has identified shortcomings in relation to the Duty of Candour. I would expect the Health Board to take this opportunity to ensure that the requirements and spirit of the Duty of Candour are fully embedded in the culture and daily practice of its clinical and complaints teams.

Recommendations

90. I **recommend** that within **1 month** of this report the Health Board should:

- a) Apologise to Mrs P for the failings identified in this report, and in particular, for issuing Mr P with Sevredol without ensuring that it was safe and failing to provide him with appropriate advice about the risks of its use.
- b) Make a financial redress payment of £2000 to Mrs P to reflect the injustices caused to Mr P and his family by these failings.
- c) Share the learning points from this case (in fully anonymised form) with all medical and pharmacy staff and remind them of their responsibilities in accordance with the NICE controlled drugs guidance, and the Health Board's Medicines Policy. This communication should highlight the importance of documenting the clinical rationale for prescriptions, and emphasise that the safe prescription of medication should be prioritised, and that clinicians should consider delaying discharge or not providing medications if necessary to achieve this. It should also urge them to make every effort to counsel patients prior to discharge about their medicines, prioritising those patients on high-risk medicines like opioids and anticoagulants and those prescribed new medicines.
- d) Share this report with the Consultant for the purposes of reflection as part of continual professional development and for consideration at their next annual appraisal.

- e) Share this report with the Health Board's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.
- f) Share this report with the Health Board's Quality and Patient Safety and Audit Committees to consider my findings and include its learning from these recommendations in its Annual Duty of Candour report.

91. I **recommend** that within **6 months** of this report the Health Board should:

- g) Carry out a review of process and practice within the medical and pharmacy teams to address **all** the failings identified in this report. The review should be coordinated with the involvement of senior management and the medical directors within the relevant directorates. It should:
 - Investigate and provide assurance that all prescriptions are subject to all appropriate checks and enquiries by the prescriber and by the pharmacist on the ward (see paragraph 43), and where this is not possible that the same steps are carried out by a pharmacist prior to discharge.
 - Identify actions to improve multiprofessional working and communication between the medical and pharmacy teams.
 - Consider whether the process for completing an interim discharge summary should be amended to include information about whether the prescription was new, or pre-admission.
 - Identify and address barriers to clinicians accessing information about prescriptions from GP practices in England.
 - Consider whether DMRs are being used where appropriate, and to address any barriers to their use for cross-border patients.

As part of the review, the Health Board should conduct an audit of randomly selected discharges from the AMU from the past 6 months to determine whether the prescriptions provided on discharge were subject to appropriate checks in accordance with relevant internal and external standards. The Health Board should provide the Ombudsman with the outcome of the review and the audit along with an action plan to address any instances of non-compliance identified during the audit.

92. I am pleased to note that in commenting on the draft of this report **the Health Board** has agreed to implement these recommendations.

Michelle Morris

5 June 2026

Michelle Morris

Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Website: www.ombudsman.wales
Follow us on X: @OmbudsmanWales

Audit, Risk and Assurance Committee

STANDARDS OF BUSINESS CONDUCT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol **Executive Summary**

The Internal Audit report BCU-2526-04 provides **Limited Assurance** over the Health Board's arrangements for declarations of interest, gifts and hospitality. While some improvement has been recognised, significant weaknesses remain in reporting, data quality, monitoring, follow-up and escalation.

Required quarterly reporting did not take place, and the information previously presented to the Audit, Risk and Assurance Committee did not provide sufficient visibility of compliance, exceptions or areas of non-compliance. Arrangements for identifying and escalating overdue, unapproved or otherwise non-compliant declarations are not yet sufficiently formalised or consistently evidenced.

Management actions are due by 31 October and 31 December 2026. These include establishing the formal reporting cycle, reconciling Declare and ESR data, introducing documented follow-up and escalation arrangements, targeting individuals who have not complied and strengthening oversight of consultants undertaking private practice.

The Audit, Risk and Assurance Committee is asked to scrutinise whether the actions, ownership, timescales and evidence requirements are sufficient to address the Limited Assurance opinion and to require a further exception-based report demonstrating measurable improvement.

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Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	8 April 2026	Approved
Governance and Regulation Group	12 October 2026	Noted the report but acknowledged more work to do including clarity of escalation and compliance by budget holders

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

Declare	This is the software used to track Declarations of Interest
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STANDARDS OF BUSINESS CONDUCT

1. Y SEFYLLFA SITUATION

- 1.1 Internal Audit has completed a review of the Health Board's arrangements for Declarations of Interest, Gifts and Hospitality and concluded a Limited Assurance opinion. The review identified weaknesses in reporting, monitoring, escalation and compliance arrangements, requiring management action to strengthen oversight, improve assurance and demonstrate sustained compliance with the Standards of Business Conduct Policy.

2 Y CEFNDIR BACKGROUND

- 2.1 The Health Board's arrangements for Declarations of Interest are set out within the Standards of Business Conduct Policy, applying to Board Members and relevant staff. These arrangements include the completion of annual declarations, ad-hoc updates where interests change, maintenance of live registers, and routine scrutiny through the Governance and Regulatory Executive Delivery Group (EDG) and the Audit, Risk and Assurance Committee via the Corporate Governance Report.
- 2.2 Directors are individually and collectively responsible for ensuring that all decision-makers within their areas of accountability understand, comply with, and uphold the Health Board's Standards of Business Conduct and requirements for the declaration and management of interests. This includes ensuring that:
- All staff involved in decision-making, whether clinical, operational, financial or governance-related, are aware of their obligation to declare any personal, financial, professional or family interests that could, or could be perceived to, influence their judgement. This reflects the principle that the onus for declaring interests rests with the individual, as emphasised in the Standards of Business Conduct Policy.
 - Decision-makers are reminded regularly of their responsibilities, including on appointment, annually, and whenever new interests arise, in line with the requirements placed on Board members within Standing Orders.
 - Robust local arrangements are in place to support timely declaration, including annual prompts, directorate governance processes, and escalation routes where concerns arise.
 - Directors ensure the accurate recording, maintenance and review of registers of interests relevant to their functions, and that any declared interests are appropriately considered and managed during decision-making processes (e.g. through recusal or alternative oversight).

- Directors promote a culture of openness and transparency, ensuring staff feel confident to declare interests and understand the implications of non-compliance.

3 **MATERION PENODOL I'W HYSTYRIED** **SPECIFIC MATTERS FOR CONSIDERATION**

3.1 2025/26 Draft Internal Audit Findings

Draft Internal Audit report BCU-2526-04 concluded a **Limited Assurance** opinion on the Health Board's arrangements for Declarations of Interest, Gifts and Hospitality. While recognising progress since the previous review, the audit identified weaknesses in reporting, monitoring, escalation and compliance arrangements which require further management action before the control framework can be considered effective and operating consistently.

The audit identified that reporting had not been undertaken in accordance with the Standards of Business Conduct Policy and that existing reports did not provide sufficient information to support oversight of compliance, exceptions and non-compliance. Weaknesses were also identified in the arrangements for identifying, monitoring and escalating overdue or incomplete declarations, together with limitations in the current reporting functionality available through the Declare system.

Management has agreed an action plan to address the findings, including:

- establishing a formal reporting cycle through the Governance and Regulatory EDG and Audit, Risk and Assurance Committee;
- reviewing the Standards of Business Conduct Policy and governance arrangements to clarify oversight and accountability;
- implementing documented arrangements for the monitoring and escalation of non-compliance;
- reconciling declaration records against ESR data;
- undertaking targeted follow-up of outstanding declarations; and
- strengthening oversight arrangements relating to private practice declarations.

The majority of actions are scheduled for completion by 31 December 2026 and will be monitored through the Governance and Regulatory EDG. Future reports to the Audit, Risk and Assurance Committee will provide evidence of implementation, compliance trends and the effectiveness of the actions taken in addressing the Limited Assurance opinion

3.2 Registers of Declarations of Interest

Internal Audit identified no issues through its sample testing of Board Member declarations against Companies House and Charity Commission records. Since that testing, changes in Board membership have required the register to be updated. The Corporate Governance Team is confirming that departing

members are removed promptly, new members complete declarations on appointment, and the published register accurately reflects the current Board membership. Completion of this work will be reported through the next Standards of Business Conduct update to the Audit, Risk and Assurance Committee.

Below are the two registers of interest shared publicly, the first is that of Board Members the second is that of Employees who are 8c and above as defined in the Standards of Business Conduct Policy as those who should declare.

- Board Member Declarations can be found:
bcuhb.nhs.wales/about-us/board-members/register-of-board-members-declarations-of-interest-131026/?ts=1791972147617
- The current system of reporting declarations of interest and gifts and hospitality is an area of improvement that is highlighted in terms of the Corporate Governance Improvement Plan for 2026/27. This information provides a link to the register and going forward, it will be monitored by the Corporate Governance Team reporting on any breaches to the policy.
- Declarations for those 8c and above can be found here:
<https://bcuhb.mydeclarations.co.uk/declarations>

Whilst some progress has been made; the current reporting system makes it challenging to prepare reports to demonstrate compliance; whilst there is work being progressed in this area; there still needs to be a focus on ensuring decision makers are declaring in accordance with the Standards of Business Conduct Policy. Work is ongoing to change the way in which Declarations are recorded to work with the Electronic Staff Record which will enable the declarations to be

There are 408 budget holders within scope.

- 2025/26: 133 declarations were completed, including 112 nil declarations. 275 budget holders had no declaration recorded.
- 2026/27 to 18 September 2026: 52 declarations were completed, including 39 nil declarations. 356 budget holders had no declaration recorded.

It should be noted that individuals may submit more than one declaration during the reporting period. The number of declarations therefore does not necessarily equate to the number of individual budget holders who have declared, and the figures should be interpreted accordingly.

Decision Makers (8c and above)

- Number of budget holders. - **408**
- Number who have completed a declaration.
01/04/2025 – 31/03/2026 – **133**
01/04/2026 – 18/09/2026 - **52**
- Number who have completed a nil declaration.
01/04/2025 – 31/03/2026 – **112**
01/04/2026 – 18/09/2026 - **39**
- Number with no declaration recorded.
01/04/2025 – 31/03/2026 – 275
01/04/2026 – 18/09/2026 - 356

Prior to the next Audit, Risk and Assurance Committee meeting, the Corporate Governance Team will undertake a review of publicly available Association of the British Pharmaceutical Industry (ABPI) disclosures, investigate any material discrepancies with recorded declarations of interest, and report findings, exceptions and actions taken to the Committee.

3.3 Strengthening compliance and oversight

Further work is required to strengthen the oversight and reporting of declarations of interest. The current presentation and quality of the available data makes it difficult to consistently identify areas, directorates or staff groups where compliance is lower. Improving the accuracy, consistency and presentation of this information will therefore be a priority, enabling clearer analysis by directorate, staff group and seniority and more targeted action where gaps are identified.

Executive Directors will be expected to provide active oversight within their areas, with particular attention to Band 8c and above and other relevant decision-makers. This will include reinforcing the requirement to make declarations on appointment, annually and whenever circumstances change, and ensuring that identified gaps are followed up.

The Corporate Governance Team will review and strengthen the supporting guidance and communication arrangements so that staff and managers are clear about who is required to declare, what should be declared and when declarations need to be updated. Clear arrangements will also be maintained for the escalation of significant, repeated or unresolved non-compliance.



The Governance and Regulatory Assurance Group will provide an additional level of oversight, reviewing compliance information, identifying areas requiring further action and monitoring progress against agreed improvements. Significant or recurring areas of concern will be escalated through the appropriate governance route.

Routine reporting to the Audit, Risk and Assurance Committee will then provide a clear line of sight from operational and management oversight to Board-level assurance, focusing on compliance, exceptions, actions and improvement over time. This will enable the Committee to identify where material gaps remain, understand the action being taken and assess whether those actions are resulting in sustained improvement.

3.4 Gifts and Hospitality

A review of the Gifts Register identified 10 gift declarations recorded up to 30 September 2026, comprising seven relating to 2026/27 and three relating to 2025/26. Nine declarations had recorded approval and one was recorded as not approved.

Corporate Governance review found that eight declarations were compliant with the Standards of Business Conduct Policy. Two declarations were identified as outside the requirements of the Policy and were followed up with the relevant decision-makers.

For the declaration relating to a cash gift, it was clarified with the decision-maker that the cash had subsequently been donated to charity. The second declaration related to gift vouchers intended for the purchase of equipment for staff use and was referred back to the decision-maker for appropriate clarification.

Category	Number of declarations
Flowers, food and drink	3
Personal / commemorative gifts	3
Gift vouchers	2
Cash	1
Other	1
Total	10

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

Work has taken place to improve awareness of the requirements for Declarations of Interest, alongside the development of a new reporting approach tailored to the Health Board. This work is ongoing, with the proposed reporting solution nearing finalisation.

The next phase will focus specifically on strengthening compliance and oversight for Gifts and Hospitality. This will include:

- issuing a targeted communication to staff setting out the requirements for declaring Gifts and Hospitality;
- ensuring Directors reinforce these requirements within their directorates;
- reviewing the quality and completeness of Gifts and Hospitality information currently recorded and following up identified gaps;
- introducing routine monitoring of Gifts and Hospitality alongside Declarations of Interest;
- reporting compliance, exceptions and outstanding actions to the Governance and Regulatory Assurance Group for management oversight; and
- providing the Audit, Risk and Assurance Committee with regular reporting on compliance, areas of concern and progress against actions.

This will provide a clearer route from individual and directorate responsibility, through management oversight by the Governance and Regulatory Assurance Group, to assurance and scrutiny by the Audit, Risk and Assurance Committee.

5 ARGYMHELLION RECOMMENDATIONS'

5.1 Gofynnir i'r Pwyllgor/ The Committee is asked to:

- **REVIEW** the current position in relation to Declarations of Interest, Gifts and Hospitality;
- **ENDORSE** the actions being taken to strengthen compliance, reporting and Executive Director oversight, including the development of the new reporting approach;
- **AGREE** that progress, exceptions and areas of continued non-compliance are monitored through the Governance and Regulatory Assurance Group, with material matters and progress reported to the Audit, Risk and Assurance Committee.

ASESIAD / ASSESSMENT

Cyswllt â'r Blaenoriaethau
Strategol
Link to Strategic Priorities

    
4. Create a modern, people Centred Healthcare System

	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	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)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublicSectorEqualityDuty[HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
	Canlyniad/Outcome:	

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	

<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☒ Canlyniad/Outcome:	Naddo/No: ☐ Counter Fraud have full access to the Declare system so they are able to scrutinise declarations.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



Audit, Risk and Assurance Committee

Decision Making and Prioritisation Framework

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Phil Meakin, Associate Director of Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

A Decision Making and Prioritisation Framework has been developed as part of the work to clarify operational governance arrangements in the health board. The framework was approved by the Executive Committee on the 23 September 2026 and is being received at the Audit, Risk and Assurance Committee for consideration and assurance.

The Decision Making and Prioritisation Framework ensures the health board has a single consistent and transparent approach to prioritisation and decision-making. It aligns with the Governance and Accountability Framework, the Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions (SFI) and Welsh Government requirements.

The development of the framework has been informed by a number of reports to, and feedback received from Executive Committee. It has also been informed by a report to Audit Committee on the 18 August 2026 where proposed changes to the Scheme of Reservation and Delegation (SoRD) were endorsed for onward approval at the Board in September 2026 as discussed in previous Executive Committee meetings.

The report also contains an operational governance arrangements document that provides senior service leads with clearer guidance on discharging their governance

responsibilities. These operational governance arrangements have been developed as part of the Foundations for the Future (FFtF) programme, however the principles established in the document equally apply to the current operating model.

Recommendations

The Audit, Risk and Assurance Committee is asked to:

- **Consider and Receive Assurance** on the development of a Health Board Decision Making and Prioritisation Framework.
- **Note** the development and mobilisation of the Operational Governance Arrangements document.

List of Additional Information:

- The Decision Making and Prioritisation Framework
- Operational Governance arrangements

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Audit Committee	18 August 2026	Approved the proposed changes to the Scheme of Reservation and Delegation (SoRD) for onward approval at the Board in September 2026 as discussed in previous Executive Committees
Executive Committee (Formal)	23 September 2026	Approved the Decision Making and Prioritisation Framework
Executive Committee (Informal)	5 August 2026	Discussion on both the Draft Decision Making Framework and Operational Governance Requirements. Outcome was to rename and reflect as the Decision Making and Prioritisation Framework and that the Operational Governance document be “arrangements” rather than a “Framework”. Discussion on the amendments needed to the Schedule of Reservation and Delegation and that this would be considered at Audit Committee.

Executive Committee (Formal)	15 July 2026	Operational Governance Framework and Decision Making Framework presented.
Executive Committee (Informal)	8 March 2026	Presented on key principles of an Operational Governance AND Decision Making Framework.

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	

DECISION MAKING AND PRIORITISATION FRAMEWORK

1. Y SEFYLLFA/SITUATION

- 1.1 The purpose of this report is to enable the Audit, Risk and Assurance Committee to consider and be assured on the development of the health board Decision Making and Prioritisation Framework.

2. Y CEFNDIR/BACKGROUND

- 2.1 The Informal Executive Committee supported the proposed key principles of a health board Operational Governance Arrangements document on the 18 March 2026 and supported the refresh of the health board Decision Making (DMF) Framework. Since then, there has been significant engagement with Senior Service managers, FFtF Programme Director and Internal Audit and two workshops that took place in June 2026 that have influenced the refresh of the Draft Decision Making Framework and development of Operational Governance arrangements.
- 2.2 On 15 July 2026 Executive Committee received a Draft Decision Making Framework and a Draft Operational Governance Framework.
- 2.3 On 5 August 2026, an informal Executive Committee discussion guided the development of the Operational Governance Framework to be an Operational Governance *Arrangements* document (rather than framework) that could now be used to support Senior Service leads in the discharge of their governance responsibilities. In relation to the Decision Making Framework, it was agreed that the naming of it should be the “Decision Making and Prioritisation Framework” as it contains a prioritisation scoring mechanism to support effective decision making.

- 2.3 On the 18 August 2026 the Audit Committee considered and endorsed amendments to the health board Schedule of Reservation and Delegation ahead of consideration for approval by the Board on 25 September 2026. The changes included revisions to delegated financial limits, clarification of escalation arrangements through Executive Committee, and a number of updates to improve consistency and alignment with current organisational arrangements. The refreshed Decision Making and Prioritisation Framework now reflects these amendments and was approved by Executive Committee on 23 September 2026 subject to a single amendment which has now been made.
- 2.4 The development of this Decision Making and Prioritisation Framework is also complementary to the health board Integrated Planning Framework (for example, in relation to Business Case development).
- 2.5 The importance of significant engagement with health board colleagues is a clear next step and should include communicating the approach to Business Case development (as noted above). This engagement should also include further documentation of decision making examples with operational services. This will allow the framework and operational governance arrangements document to be used to provide ever improving clarity on decision making routes.
- 2.6 The operational governance arrangements document has been developed as part of the Foundations For the Future programme, however the principles established in the document equally apply to the current operating model. It is the intention to start to mobilise the operational governance arrangements noting that a review of the arrangements will be necessary if the nature of service provision develops.

3. MATERION PENODOL I'W HYSTYRIED/SPECIFIC MATTERS FOR CONSIDERATION

- 3.1 For the Audit, Risk and Assurance Committee to consider and be assured on the development of the Decision Making and Prioritisation Framework.
- 3.2 To note the benefit from continued engagement with health board colleagues in relation to both the Framework and the mobilising of the operational governance arrangements. In particular further framing of practical decision making examples will help bring relevance to the framework and provide further clarity on decision making.

4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

- 4.1 The main risk associated with this report is not having a current Decision Making and Prioritisation Framework for the health board.

5. ARGYMHELLION RECOMMENDATIONS

The Audit, Risk and Assurance Committee is asked to:

- **Consider and Receive Assurance on** the development of a Health Board Decision Making and Prioritisation Framework.
- **Note** the development and mobilisation of the Operational Governance Arrangements document.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	Choose an item.
	See below
	More than one applies, please list below: <ul style="list-style-type: none"> • Building an Effective Organisation • Developing strategy and long-lasting change • Improving quality, outcomes and experience • Establishing an effective environment for Learning
Yr Egwyddorion Dylunio Design Principles	<ul style="list-style-type: none"> • People First • Inclusive Design • Simplify, Standardise and Adopt Best Practices • Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Failure to approve and consistently apply a Decision Making Framework structure would perpetuate inconsistent decision-making and escalation routes, increasing the risk that governance and assurance does not meet the requirements of the proposed operating model.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>There are no specific implications related to the activity outlined in this report.</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>There are no specific implications related to the activity outlined in this report.</i>

<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality	Meysydd Ansawdd Domains of Quality All Apply
	<i>There are no specific implications related to the activity outlined in this report.</i>	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There are no specific implications related to the activity outlined in this report.
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There are no specific implications related to the activity outlined in this report.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There are no specific implications related to the activity outlined in this report, however a refreshed framework further mitigates against counter fraud impacts through enhanced clarity on decision making
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below)	
	The ability to services to operate with effective governance will mitigate the risk of adverse quality and safety matters arising	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

DECISION MAKING AND PRIORITISATION FRAMEWORK

2026-2028



Author & Title	Pam Wenger Director of Corporate Governance Phil Meakin Associate Director of Governance		
Responsible Department / Director:	Corporate Governance Pam Wenger Director of Corporate Governance		
Approved by:	Executive Committee - 15 July 2027 (Key Principles) Executive Committee – 23 September 2026		
Date approved:	23 September 2026 by Executive Committee		
Date activated (live):			
Documents to be read alongside this document:	Scheme of Reservation & Delegation (SoRD) Standing Financial Instructions (SFIs) BCUHB Integrated Planning Framework BCUHB Integrated Performance Framework BCUHB Risk Management Framework BCUHB Values and Behaviours BCUHB Design Principles All Wales Procure to Pay e-Manual for use by Health Organisation Colleagues Direct Awards Against a Framework Agreement		
Date of next review:	28 Sept 2027		
Date EqIA completed:	N/A		
First Operational:	add November 2025		
Previously reviewed:	N/A	Yes	
Changes made yes:	Not approved	Major revisions	

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The BCUHB Intranet should be referred to for the most current version of the document and relevant references.

Contents

1. Introduction	4
2. The BCUHB Decision Making Approach	6
2.1 Decision vs Delegation Matrix	7
2.2 Financial Delegations	12
3. Prioritisation Categories	16
3.1 Prioritisation	20
3.2 Scoring Prioritisation	21
3.3 Scoring Impact/Score Determinants	23
3.4 Governance & Meeting Structure	24
3.5 Decision Making Flow Chart	26
3.6 Service Change	27
4. Integration with Procurement	27
5. Statutory Duties in Decision Making	27
6. Legal Advice	28
7. Conclusion	28
Appendix	29
Appendix 1 Glossary	29
Appendix 2 Health Board's Risk Appetite 2025/2026	30
Appendix 3 - Summary of Key Statutory Duties	31
References	32

1. Introduction

1.1 Context

The Decision Making and Prioritisation Framework ensures the Health Board has a single, consistent, and transparent approach to prioritisation and decision-making. It aligns with the Governance and Accountability Framework, the [Scheme of Reservation and Delegation \(SoRD\)](#), [Standing Financial Instructions \(SFI\)](#) and [Welsh Government requirements](#), and should be read in conjunction with these documents to ensure compliance. This Framework is one in a series of enabling 'building blocks' which form part of a wider decision support system.

Given the wide range of responsibilities and services within the Health Board, there is no single universal prioritisation approach to decision making that would meet every case. The Framework exists as a foundational standard, allowing others to adapt and build upon its core components.

A simple guide to the Decision Making and Prioritisation Framework is available [with this link](#)

BCUHB 'Guiding Design Principles' and 'Values and Behaviours': The Health Board's [Guiding Design Principles](#) are supported, for example through 'Principle 2. Inclusive – bringing together the right people to collaborate and co-design services' and 'Principle 3. Wise Spending aligning best value and quality within available financial resources. Organisational [Values and Behaviours](#) including 'Compassion, Openness' and 'Respect', are reflected in the design of this framework. Promoting respect and transparency through engagement with Health Board colleagues.

Diagram 1 and 2 BCUHB Guiding Design Principles



Diagram 2 – BCUHB Guiding Design Principles

Principle	Overview	Considerations
1) People first	Prioritise a people centred approach to support better health and well-being outcomes.	<ul style="list-style-type: none"> Am I improving outcomes for people? Whose life am I making better? The Health Board's Wellbeing Objectives
2) Inclusive	Bring together the right people to collaborate and co-design services.	<ul style="list-style-type: none"> Have key stakeholders' been involved? For example, service users, carers, families, staff, other partners and those with relevant technical expertise.
3) Wise spending	Best value (outcomes, experience, cost)	<ul style="list-style-type: none"> Will this decision improve value in terms of outcomes wise spending and cost
4) Simplify, standardise and adopt best practice	Recognise complexity, streamline and reduce inappropriate variation.	<ul style="list-style-type: none"> Learn from others and apply best practice Is there a recognised standard, process or policy to benchmark against? Have the different aspects/consequences of change been considered? Keep it simple for the public
5) 'Digital first'	Adopt and promote new ways of working, harnessing the potential of digital innovation.	<ul style="list-style-type: none"> Seek advice and guidance from the Health Board's Digital, Data and Technology Team.
6) Equity and accessibility	Equitable and accessible services which take account of the diverse needs of the communities we serve.	<ul style="list-style-type: none"> Does this decision promote fairness and equality of access? Seek advice and guidance from the Health Board's Equalities Team Consider the Welsh Language.
7) Consistent with the Health Board's Values	The Health Board values, guide behaviours and decision making.	<ul style="list-style-type: none"> Does this decision align with the organisation's values?

The Decision Making and Prioritisation Framework strengthens the Health Board's governance arrangements and the ability to deliver its ambition and plan; improving health outcomes through a high-quality health service.

1.2 Scope

The Decision Making and Prioritisation Framework aspires to operate at any level of the organisation, and its general principles and concepts can be adapted to a wide range of cases with a flexible and proportionate approach. This Framework serves as a baseline standard, designed to be adapted and refined to meet specific needs and circumstances.

The Framework offers a consistent set of guiding principles rather than a ready-made toolkit as a flexible foundation to build upon and evolve. It emphasises the importance of using a repeatable methodology to reach evidence-based decisions, that can be documented, reviewed and audited.

Patient and public involvement is integral to the Framework, ensuring that decisions have taken account of the diverse needs of the population of north Wales. This can be achieved for example through stakeholder reference groups, co-production workshops or advisory panels.

2. BCUHB Decision Making and Prioritisation Approach

Decisions should be escalated or initiated through this Framework when triggered by events such as:

- Strategic programme (local or national)
- Service change (temporary or permanent)
- New national guidance, legislation or policy requirement
- Introduction of a new service
- Contract expiry or renewal
- Contract notice from provider
- Identified quality or safety issue
- Significant patient, staff, or public feedback
- Annual planning and commissioning cycles
- Failure to demonstrate clinical and cost-effectiveness
- Service not meeting statutory responsibilities
- Low priority or limited value relative to alternatives

The BCUHB Decision-Making Flow (In Section 3.5) sets out a simple process to make sure all decisions clinical, operational, financial or strategic are handled in a consistent way. It takes staff through clear steps: understanding what has triggered the decision, looking at the wider impact, considering any financial or service effects, confirming who should make the decision, and sending it to the right meeting or group. Diagram 3 below sets out a summary of decision making and prioritisation steps.

Diagram 3 BCUHB Decision Making and Prioritisation Steps



2.1 Decision vs Delegation Matrix

This framework supports clarity on matters reserved for decision and those appropriate for delegation, ensuring that strategic, statutory and high-risk issues are determined at the appropriate senior level, while routine operational delivery is delegated within defined parameters and with clear accountability.

Decision-making. Two principles of decision and delegation:

1. Decision

A formal choice or judgment made by the Board or Executive Committee or Senior Responsible Person with financial authority. These decisions typically relate to strategic direction, statutory obligations, organisational risk, or high-impact issues requiring corporate oversight.

Examples of Board decisions:

- Approving the financial recovery strategy
- Setting organisational priorities
- Agreeing risk appetite (Appendix 2)

2. Delegation

The assignment of responsibility and authority to individuals or teams to act within defined parameters. Delegation supports effective operational delivery, implementation, and detailed planning within established frameworks.

Examples:

- Departmental cost-saving initiatives
- Recruitment controls within policy
- Day-to-day budget management

The Decision vs Delegation Matrix below clarifies how different types of activity are handled, ensuring that strategic matters remain with the Executive Committee and/or the Board, while operational implementation is appropriately delegated. Decisions should be taken at the highest level where they affect strategic direction, statutory duties, or carry significant financial or reputational risk. Delegation applies to routine operations within agreed policies, with clear accountability for compliance and reporting.

Table 1 - Decision v Delegation Matrix

Area (Standing Orders category)	Board – Matters Reserved for Decision	Executive – Decision Authority	Delegated – Operational Delivery
Strategy	Determine strategic aims, objectives and priorities; approve key strategies and plans	Translate strategy into delivery plans; prioritisation within agreed strategy	Delivery of plans, programmes and service developments within approved strategy
Financial Stewardship	Approve budgets, financial plans and major financial decisions; write-offs above delegated limits	Deliver financial plans; agree recovery actions within Board-approved framework	Day-to-day budget management; cost control and financial monitoring
Governance & Control	Approve Standing Orders, SFIs, Scheme of Delegation and governance framework	Maintain and implement governance arrangements; ensure compliance	Application of policies and procedures in day-to-day operations
Risk & Assurance	Set risk appetite; oversee principal risks and system of control	Manage risk within appetite; escalate significant risks	Local risk management and reporting within agreed frameworks
Statutory & Compliance	Ensure compliance with statutory duties and Welsh Government requirements	Implement statutory requirements and regulatory actions	Operational compliance and evidence of adherence
Commissioning	Approve commissioning strategies and major service changes	Approve significant changes within delegated thresholds	Contract management, service delivery and performance management
Organisation	Approve committee structures, terms of reference and governance arrangements	Establish internal management arrangements within agreed structures	Day-to-day team management and workforce deployment
High impact / Exceptional	Decisions with significant financial, reputational, or safety impact; litigation and major claims	Manage and escalate issues within thresholds	Routine issue resolution and escalation where required

Table 2 - Decision vs Delegation Matrix:

Area	Decision (Retained by Board)	Decision (Executive)	Delegation (Operational Delivery)
Performance Management	Approve performance objectives and oversight arrangements, and receive assurance on delivery, performance, risks and corrective action.	Approve performance management frameworks, monitor organisational performance, direct recovery actions and escalate significant risks or failures to the Board. reserved. Recommend the Health Board's risk appetite and tolerance to the Board for approval and oversee its application in decision-making and performance management.	Deliver agreed performance objectives, implement improvement actions and escalate performance risks, exceptions and delivery concerns.
Commissioned / Externally Provided Services	Approve commissioning strategies and significant changes to externally provided services, and receive assurance on quality, performance, value for money and strategic outcomes.	Approve commissioning arrangements, contract awards, extensions, variations and termination of externally provided services within delegated authority, and recommend matters above delegated thresholds to the Board	Manage commissioned services and contracts within delegated authority, monitor performance and compliance, and escalate significant risks, performance concerns or proposed service changes.
Financial Management	Approve the financial strategy, annual budget, financial recovery plans and financial framework, and receive assurance on financial performance, stewardship and delivery.	Manage financial performance within the Board-approved framework, recommend budgets and recovery plans for Board approval, and approve the allocation and use of resources within delegated authority.	Manage budgets and resources within delegated limits, deliver financial plans, and escalate actual or forecast variances, risks and pressures.
Workforce	Approve workforce strategies, establishment principles and workforce control frameworks, and	Approve workforce control measures, establishment changes, recruitment controls and	Manage workforce establishments and recruitment within approved budgets,

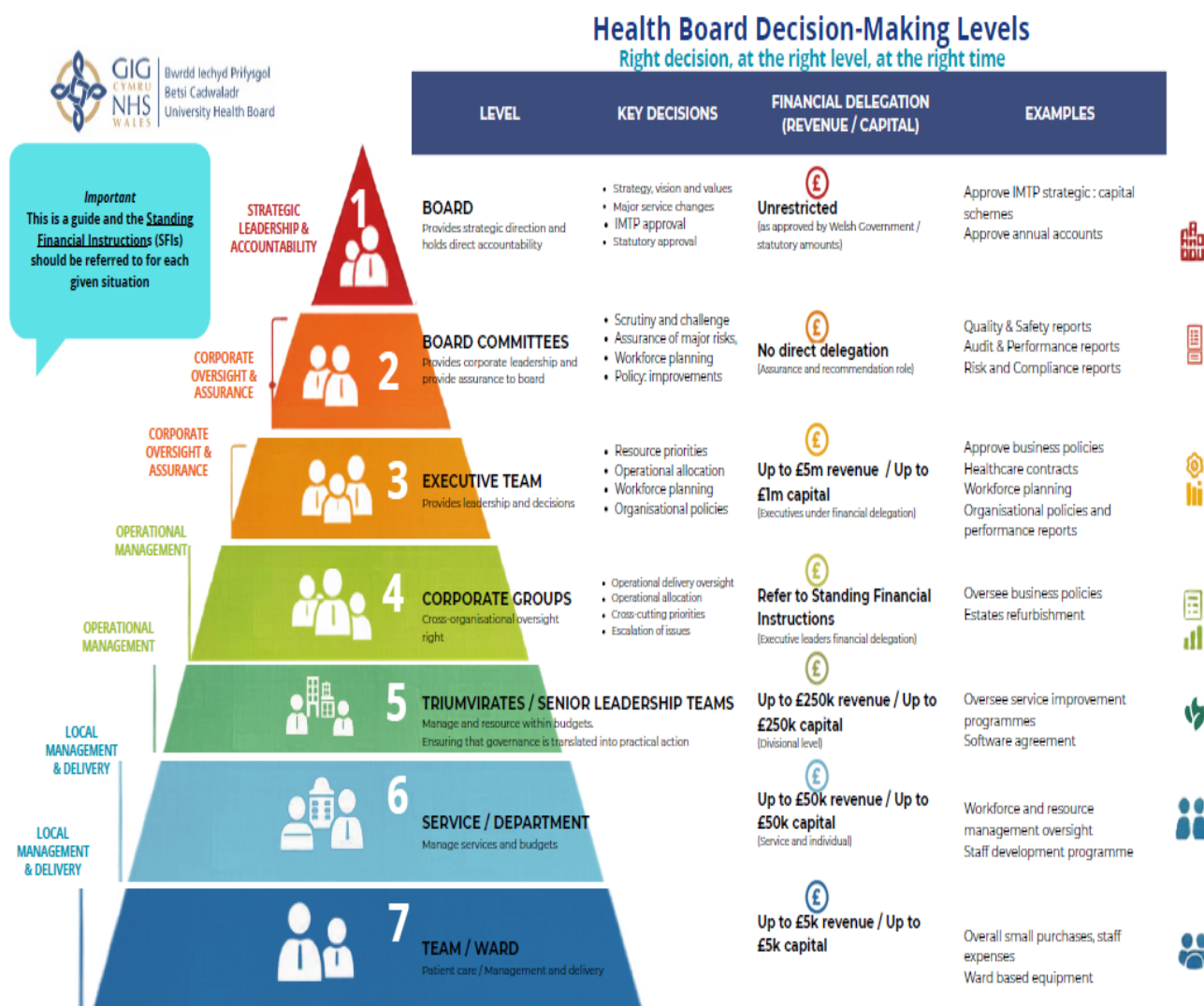
Area	Decision (Retained by Board)	Decision (Executive)	Delegation (Operational Delivery)
	receive assurance on workforce performance, affordability and sustainability.	senior appointments within delegated authority, and oversee delivery of workforce plans.	policies and delegated authority, escalating exceptions for approval.
Risk Management	Approve the risk management framework and risk appetite and receive assurance on the effectiveness of risk management and internal control.	Implement the Board-approved risk management framework, recommend risk appetite for Board approval, and approve risk tolerance, escalation thresholds and risk management arrangements.	Identify, assess and manage risks within delegated authority, implement controls and escalate risks that exceed agreed tolerance or escalation thresholds
Non-Pay Expenditure	Approval of discretionary spend policy	Approve discretionary spend controls and expenditure policies within delegated authority and oversee compliance with agreed financial recovery and control measure	Authorise discretionary expenditure within delegated limits and approved policies, escalating exceptions or proposed departures from agreed controls.
Governance Framework	Approve the Health Board's decision-making framework, Scheme of Reservation and Delegation, and Standing Orders, and oversee their effective operation	Develop and implement decision-making and delegation arrangements within the framework approved by the Board, and recommend material changes to delegated authorities for Board approval	Exercise delegated authority in accordance with approved decision-making and delegation arrangements, escalating matters beyond delegated limits or risk thresholds

Decisions with strategic, statutory, financial, service or reputational implications remain reserved for the Board in accordance with the Standing Orders and the Schedule of Matters Reserved to the Board. Operational decisions may be delegated within approved frameworks, policies and delegated authority limits. The Executive Committee oversees the operation of these arrangements, including compliance, performance and escalation of matters requiring Board consideration.

2.2 Financial Delegations

All decisions must comply with the financial and operational thresholds in the Schedule of Reservation and Delegation (SoRD) and Standing Financial Instruction (SFIs). Indicative thresholds for investment and disinvestment are detailed below. Diagram 4 provides a summary of this.

Diagram 4 – Summary of Health Board Decision Making Levels



2.3 Financial Delegations

Table 3 below should be read alongside the Standing Financial Instructions (SFIs), Standing Orders and Scheme of Delegation. It sets out the delegated authority levels for approving contracts, expenditure, invoices and purchasing decisions, including contracts for goods and services, capital schemes, Service Level Agreements (SLAs) and Memoranda of Understanding (MoUs) with non-NHS organisations. Delegated authority must be exercised within the financial limits and conditions specified below.

Table 3 – Financial Delegation

TIER	FINANCIAL DELEGATION	Authority Delegated to	Approvers	Practical Examples
0	Board	Above £1,000,000	Chief Executive following approval by Board and Welsh Government	New department development; major digital system investment.
1	Chief Executive	Up to £1,000,000	Chief Executive	£900k estates project; cross-division service redesign.
2	Executive Director of Finance Deputy Chief Executive	Up to £500,000	Executive Director of Finance or Deputy Chief Executive	£450k diagnostic equipment purchase.
3	Executive Directors	Up to £300,000	Executive Directors	Workforce redesign pilot across IHC *Executive approval is required above £250k for non-NHS providers.
4	Senior Officers (<i>not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment</i>)	Up to £250,000	Senior Officers (<i>not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communication, Engagement & Partnership and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment</i>)	IT licence renewal; estates refurbishments Extension of contracts
5	Assistant / Associate / Deputy Directors or Heads of Service	Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service	Service-level equipment or software agreement up to £150,000
6	Nominated Budget Holder for specific cost centres	Up to £50,000	Nominated Budget Holder for specific cost centres	Departmental IT; local service contracts.
7	Service Lead or Site / General Manager	Up to £30,000	Service Lead or Site / General Manager	Ward-based equipment; staff development programme.

8	Contracts Manager or Head of Operations	Up to £25,000	Contracts Manager or Head of Operations	Routine consumables; operational supplies.
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Where new contracts are above £1 million, these must be approved by the Welsh Government (except for those contracts let under Sections 33 and 192 of the NHS (Wales) Act 2006 and those covered by guidance issued by the Welsh Government on "General Consent" (SFI 11.6.3).

2.4 Table 4 (Table 5B in the SORD) - Authority to commit resources above expenditure baselines set within the financial plan

Table 4 below applies when the Health Board is considering new spending above the baseline plan (e.g., new investments, service developments, or disinvestments). It sets out how new revenue cases must be approved, escalating from the Chief Executive up to the Board and Welsh Government, depending on the value. *Examples of areas not requiring consent for contracts exceeding £1m are detailed in the SORD.*

Table 4 - Authority to commit resources above expenditure baselines

Ref	Revenue Case Value	Approved by:
1	Up to £0.25m	Chief Executive (or Deputy Chief Executive) and Executive Director of Finance All approvals retrospectively reported to Executive Committee in accordance with the Terms of Reference of the Executive Committee
2	Above £0.25m, up to £0.5m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee. <i>Must align to IMTP & financial plan.</i>
3	Above £0.5m, up to £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee. <i>Requires clear Return on Investment (ROI) and deliverability.</i>
4	Above £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee plus approval by Board and Welsh Government. <i>Mandatory WG approval unless exempt under "General Consent".</i>

2.5 Other Delegations

In addition to the general financial delegations for contracts and expenditure, there are further categories of decision set out in the Schedule of Reservation and Delegation (SoRD) which staff must be aware of. This Framework provides an overview only; staff must check the relevant SoRD tables for detailed thresholds and conditions. This reflects the SoRD that was approved in March 2026 and updated in September 2026.

(i) Virement (Budget Transfers)

- Local virements within own budget may be authorised up to £100k.
- Virements between Directorates/Divisions require Executive approval for £100k–£500k.
- Virements exceeding £1m require Board approval.
See SoRD Table 5D for full details.

(ii) Grants

- Assistant Directors up to £75k; Service Directors up to £300k.
- Executive Directors jointly with the Executive Director of Finance up to £500k.
- Chief Executive or Executive Director of Finance up to £1m.
- Board and Welsh Government approval required above £1m.
See SoRD Schedule 1, Grants section, for conditions.

(iii) Losses and Special Payments

- Deputy Director of Legal Services up to £500k.
- Director of Corporate Governance up to £1m.
- Board and Welsh Government approval required above £1m.
- All such payments must be reported to the Audit, Risk and Assurance Committee.
See SoRD Schedule 1, Losses and Special Payments.

(iv) Redundancy and Compensation Payments

- *See SoRD Schedule 1, Redundancy and Ex Gratia Payments.*

(v) Primary Care Contracts

- Routine contract variations within budget may be approved by Service Directors and relevant Executive Directors.
- Significant changes, including new contracts or those exceeding £1m, require Board approval, with Welsh Government approval where the contract is NOT under a framework.
See SoRD Primary Care section 12a for detailed thresholds and exceptions.

2.6 Capital Schemes

Capital schemes fall into two categories: Discretionary Capital and General (Main Programme) Capital.

- **Discretionary Capital** is the Health Board's annual locally controlled allocation from Welsh Government. It is used for small/medium projects such as estates works, IT upgrades, or replacement equipment.
 - <£0.5m → Strategic Planning and Service Change Group (SPSC)

- o £0.5m–£1m → Executive Committee.
- o £1m → Board and Welsh Government (Strategic Outline Case (SOC)/ Outline Business Case (OBC)/ Full Business Case (FBC)).
- **General Capital** schemes are large-scale, strategic projects funded by Welsh Government (e.g., new hospital builds, Electronic Patient Record).
 - o All schemes require submission to Welsh Government (WG) at Strategic Outline Case, Outline Business Case, and Full Business Case stages, and approval at each stage by the Board.
 - o In addition to the Strategic Outline Case/Outline Business Case/Full Business Case route there are BJCs (business justification case, a single-stage case for low value/simple projects) and PBCs (programme business cases where there is more than one project within an overall programme, generally replaces a SOC for those projects). A key element of all-Wales schemes is the production of a scoping document which gives an outline of the project and sets out the intended business case route, for discussion and agreement with WG.

Golden Rules for Staff

- Always check the SoRD tables before progressing.
- If in doubt, escalate to your Director or the Corporate Governance team.
- No commitment can be made without written approval from the delegated officer(s).
- Ensure a clear business case accompanies all proposals above £0.25m.
- Record the decision, evidence, and approvals for audit purposes.

3. Prioritisation Categories

Non-financial decisions should be evaluated according to impact on strategic objectives, statutory duties, risk, and public confidence. Proposals are assessed against five core categories:

- Strategic Alignment.
- Organisational Risk.
- Deliverability.
- Value and Impact.
- Political / Reputational Imperative.

The Health Board's Decision Making and Prioritisation Framework consists of five main categories for prioritisation, designed to support decision makers to assess proposals based on the strategic and operational objectives of the Health Board (including

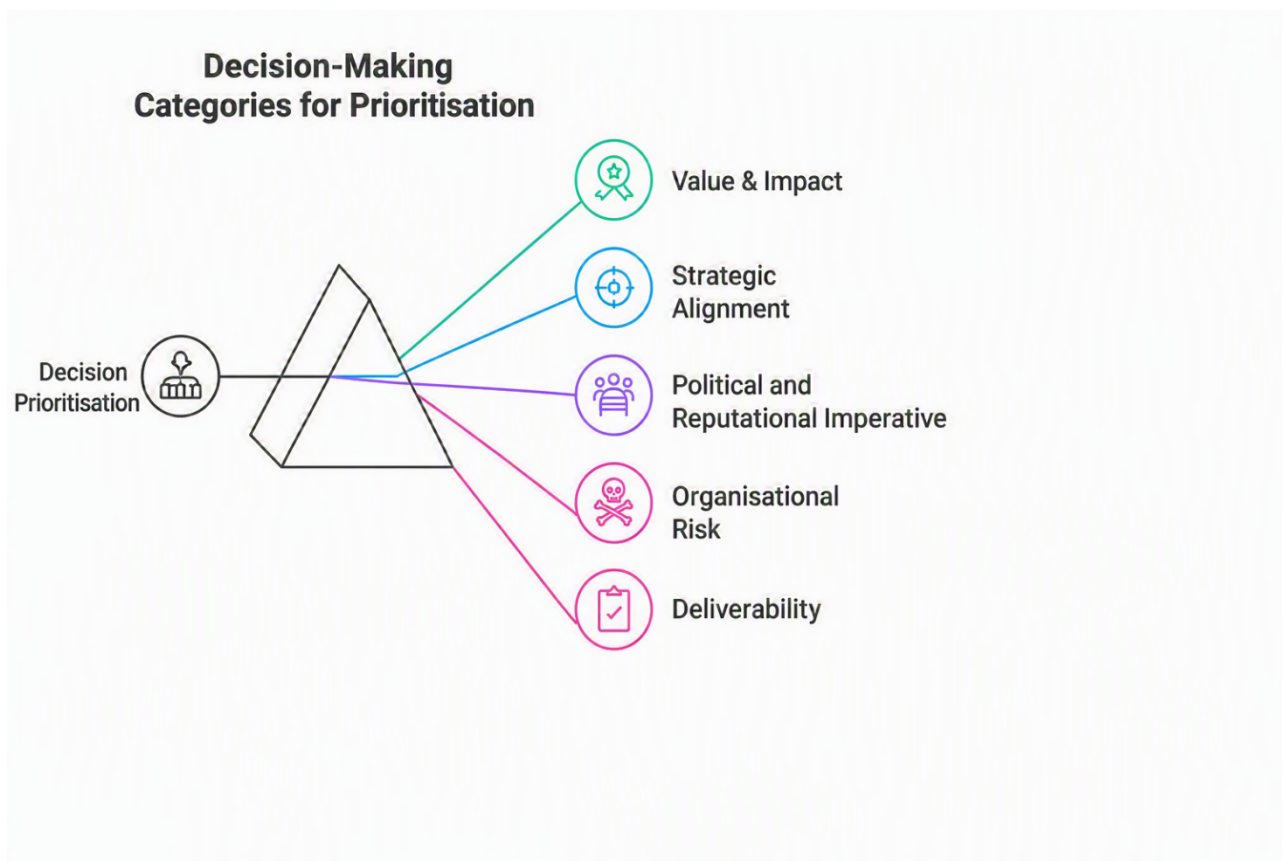
consideration of the impact on people). In this context decision makers, working with multi-professional colleagues where possible, are those people who adopt accountability for the decisions reached.

These five categories offer a step-by-step process to apply whilst critically considering and reaching decisions. The process clearly links decision maker accountability to the best available evidence, documented rationale and the Health Board's own strategic objectives. The evidence base should be drawn from a wide range of referenced sources, and where available making use of the Health Board's data quality kitemark, but care taken to avoid relying solely on raw data.

- Sustainability of Health Services (Cross-Cutting Consideration)

In addition to the prioritisation categories, decision-makers must assess how proposals affect the long-term sustainability of health services and people (workforce). Sustainability includes the capacity of the system to deliver safe, effective, and equitable care over time within available resources. Proposals with longer-term benefits (e.g., prevention, workforce resilience, environmental sustainability, digital innovation) should not be disadvantaged in scoring due to delayed return on investment. Where the impact is realised over an extended period, this should be described in the "Value & Impact" narrative and evidenced with projections or supporting data.

Diagram 4 – Decision-Making Categories for Prioritisation



N.B. These categories allow for the integration of other developing Health Board prioritisation practices, in use for example by DDAT, the Portfolio Office and in bespoke settings such as clinical innovations, applying computational models (Machine Learning and Artificial Intelligence).

1. Strategic Alignment

Measures the proposal's alignment with the Health Board's strategic objectives, national priorities (e.g. *A Healthier Wales*) and statutory obligations (e.g. Quality and Safety and Equality Legislation).

Example Questions:

- Does the proposal contribute to achieving the BCUHB strategic objectives?
- Is it in line with the IMTP, 10-year Strategy or Clinical Services Plan?

2. Organisational Risk

Assesses the proposal's ability to mitigate risks or address significant gaps in current service provision (Risk Appetite Appendix 2). Ensures risks to patient safety, financial stability or compliance are factored into prioritisation.

Example Questions:

- Does this address a Board Assurance Framework, Corporate Risk or significant operational risk?

- Does it improve compliance with statutory or regulatory requirements e.g. the Public Sector Equality Duty and Socio-economic Duty?

3. Deliverability

Evaluates the feasibility of successful implementation, considering areas such as resource (people and money), complexity, capacity, workforce, infrastructure, dependencies stakeholder buy-in, and operational readiness.

Example Questions:

- Are resources available to deliver the proposal within the proposed timeframe?
- Are there dependencies to implementation, and are they manageable?
- What is the level of urgency required in relation to implementing this decision? Is it critical for effective operations?

4. Value and Impact

The Health Board will embed a Value-Based Healthcare (VBHC) approach across its operating model to ensure that resources are directed toward achieving the best outcomes for patients. This means improving patient outcomes and experiences in relation to the cost of care, using data-driven insight to inform decisions and drive equitable, sustainable improvements. The approach brings together key dimensions of value including health outcomes and inequalities, population health, social impact, financial sustainability, environmental responsibility, and the experiences of both citizens and staff to maximise overall benefit in line with the Prudent Healthcare Principles. The long-term sustainability of services is critical, and value should be assessed across short-, medium-, and long-term timeframes to recognise both immediate impact and enduring benefits.

Example Questions:

- What is the expected impact on patient outcomes, health inequalities and population health?
- Is this safety critical?
- Does the proposal demonstrate financial sustainability, return of investment (ROI) and prudent use of resources?
- Aligned to evidence based on High Value and High Impact interventions?
- What is the expected impact on the sustainability and resilience of health services over time?
- Does this decision directly or indirectly support the overall savings goal required by the services?

Defining Outcomes:

Outcomes refer to the measurable results of healthcare interventions and decisions. These include, but are not limited to:

- Clinical outcomes (e.g., mortality, complications, recovery rates),
- Patient-reported outcomes (experience, quality of life, satisfaction),
- Operational outcomes (efficiency, capacity, flow),
- Population health outcomes (equity, prevention, reduction in health inequalities).

Decisions should describe which outcome types are expected to improve and how these will be monitored over time.

5. Political / Reputational Imperative

Assesses the extent to which the proposal addresses Welsh Government Cabinet Minister's priorities or responds to public or stakeholder expectations. It balances the organisational need to maintain trust and transparency with national and local political realities.

Example Questions:

- Does the proposal address a significant Cabinet Secretary's priority or public concern?
- Does it enhance the Health Board's reputation, public confidence levels or respond to critical scrutiny?

These five core categories provide a consistent and adaptable approach to prioritisation. It supports decision-makers with a structured approach to evaluate initiatives holistically (including the regulations related to contracting/procurement) whilst allowing for judgement and accountability. By focusing on strategic alignment, organisational risk, deliverability, value and impact and political/reputational imperative, the Framework ensures that resources are directed toward initiatives that deliver maximum benefit for citizens, communities, and the Health Board as a whole.

3.1 Prioritisation

This Framework supports a structured approach to decision-making, ensuring that resources are allocated effectively in alignment with strategic objectives, organisational priorities and best value principles. Prioritisation decisions within the Health Board must be evidence-based, transparent and repeatable, allowing for scrutiny, refinement, and continuous improvement over time. This structure allows for a quantitative analysis on the level of priority the Health Board should consider in relation to the decision.

To maintain consistency across the Health Board, this Framework outlines a structured scoring methodology:

- o A weighted prioritisation approach using a simple 0-3 scale.

The approach enables a rapid assessment of priorities and more detailed evaluations when required, ensuring that decision-making remains flexible, scalable and proportionate to the

complexity and impact of the proposal.

Templates provided in the procedural document will facilitate the structure of the proposal in line with the Framework. The template will be made available as an electronic form/

Proportional Application

The Decision-Making Framework must be applied proportionately to the scale, scope, and potential impact of the decision. Meaning not all changes require formal use of the full scoring process. Minor operational improvements, where the impact is clearly low, may be progressed through local management arrangements without completion of the formal framework.

Examples include day-to-day service adjustments, such as small changes to local processes, minor environmental or patient-comfort improvements (e.g., refreshments, waiting-room layout), or changes that affect a small cohort of patients or staff with no material impact on cost, risk, quality, ensuring statutory compliance or access to health care.

The guiding principle is that the level of governance should be proportionate to the impact of the decision.

Where the decision involves strategic change, material cost, quality/safety risk, or reputational implications, the full framework must be applied.

Where the decision is operational and low-risk, managers may record the rationale for treating it as having relatively insignificant organisational impact, but it does not require completion of the scoring template.

Directors and Heads of Service remain accountable for ensuring that decisions not requiring formal escalation are appropriate, proportionate, and consistent with the principles of good governance.

3.2 Scoring Prioritisation

The Scoring Prioritisation Approach provides a straightforward and accessible method for scoring proposals. It applies a 0-3 scale, allowing staff and Board Members to differentiate between levels of priority. Each proposal will be scored against the five core prioritisation categories, with scores aggregated to provide a total prioritisation score. Any evidence used in the process should be referenced, and the decision accompanied by a documented rationale.

However not all scores are equal. Each category is scored on a 0-3 scale, with predefined weightings applied to reflect their relative importance. The total score is calculated by multiplying each category score by its assigned weight. Any evidence used should be referenced with each weighting clearly explained, and the decision accompanied by a detailed rationale. This approach allows the Health Board to prioritise its value-based approach on a percentage basis. For example, Value and Impact could have a four times multiplier to ensure it carries more weight when totalling scores. Section 3.4 and 3.5 below provides further details on completing the template and example cases.

3.2.1 Table 5: Example: Weighted Prioritisation Scoring

Project Name	Strategic Alignment (x3)	Organisational Risk (x2)	Deliverability (x2)	Value & Impact (x4)	Political / Reputational Imperative (x3)	Total Score & %
Initiative A	3 (weighting of 3 multiplied by score of 3 = 9)	2 (4)	2 (4)	3 (12)	3 (9)	38 (90%)
Initiative B	2 (weighting of 3 multiplied by score of 2 = 6)	1 (2)	3 (6)	2 (8)	1 (3)	25 (60%)

3.2.2 Table 6: Scoring Descriptor Table

The descriptor table provides clear definitions for each score (0–3) across the five prioritisation categories. It ensures staff and Board members can apply the scoring matrix in a consistent and transparent way, reducing ambiguity and supporting evidence-based decision-making. By using these descriptors, proposals can be assessed fairly and comparably, while still allowing professional judgement to be applied alongside the numerical output.

Category	1	2	3
Strategic Alignment (x3)	Limited or indirect alignment with BCUHB strategy or national policy. Not part of statutory duties.	Partial alignment with strategy or national priorities; supports one element of the IMTP/Clinical Strategy.	Strong alignment with multiple strategic objectives, "A Healthier Wales," IMTP, and/or statutory duties.
Organisational Risk Alignment (x2)	Minimal impact on addressing key risks. Limited effect on BAF/CRR or compliance.	Addresses a moderate organisational/service risk. Improves compliance with some statutory/regulatory duties.	Directly addresses a high-level BAF/CRR risk. Major contribution to compliance, quality, and safety.
Deliverability (x2)	Significant workforce, infrastructure, or	Moderate implementation	High feasibility. Existing infrastructure,

	dependency issues. Low feasibility without major new resources.	challenges. Can be delivered with mitigation plans and phased rollout.	workforce, and resources are in place to deliver.
Value & Impact (x4)	Benefits unclear or limited. ROI not demonstrated. Sustainability uncertain.	Demonstrates some impact on outcomes, inequalities, or efficiency. Partial ROI evidenced.	High potential impact on outcomes, reducing inequalities, improving quality of life. Clear ROI and sustainability case.
Political / Reputational Imperative (x3)	Limited political/public interest. Does not address a Cabinet Secretary priority.	Some political/public interest or scrutiny. Supports one key ministerial/public priority.	High political/public interest. Directly supports Cabinet Secretary priorities and is likely to gain public/stakeholder support.

To mitigate the risk of scoring bias, the framework includes safeguards such as peer reviews, multi-professional team evaluations, and qualitative assessments to complement numerical scoring. An element of judgement is required when considering the numerical output of the scoring, and the process does not advocate following the numerical outcome alone. This judgement can be made when a designated governance forum receives the proposal for consideration.

Scores - they do not replace professional judgement. The role of a decision maker requires being mindful of the potential for unintended consequences by solely relying on a mathematical prioritisation approach. The scoring group should reference the scoring descriptions.

3.3 Scoring Impact/Score Determinants

The total prioritisation score generated through the weighted scoring process provides an indication of the overall impact, value and feasibility of a proposal. However, the score alone does not determine the decision. Section 3.6 explains how the Impact/Score Determinants should be interpreted and used to guide, rather than solely dictate, the decision-making route.

The purpose is to translate the numerical score into a clear Priority Level so that decision-makers can methodically and systematically assess how strongly the proposal aligns with BCU requirements when assessing multiple cases, the extent to which it addresses organisational risk, and how deliverable it is within current resources. Re-examining the political / reputational scoring / weighting is often a mechanism to adjust scoring, and this is an important part of this framework.

The Impact/Score Determinants help staff determine:

- whether the proposal should progress, pause, or be reconsidered
- whether the matter should be decided locally, at Directorate level, or escalated to Executive Committee/Board
- how the score interacts with statutory duties, risk considerations and professional judgement

While the weighted scoring highlights relative priority, this framework emphasises that scores inform the discussion but do not replace professional judgement. Decision-makers must consider qualitative factors, unintended consequences and wider organisational context alongside the numerical output. Disagreement within scoring groups, or a proposal with unusual features (e.g., low score but high safety implication), may justify escalation even if the raw score appears modest.

The following table sets out how the total score should be interpreted, what each priority level means, and the expected actions for staff and decision-makers.

3.3.1 Table 7: Total Impact/Score Determinants

Total Score	Priority Level	What it Means	What Staff Should Do
0–15	Low Priority	Weak case → limited alignment, low value, or poor feasibility.	Usually do not progress. Only escalate if statutory, regulatory, or safety critical. Decide at team or service level within financial delegation (Table 1) to progress or abandon proposal. Escalate only if unusual risk, reputational impact, or novel context such as high Value & Impact or escalate if near medium score and disagreement within the group.
16–30	Medium Priority	Proposal addresses some strategic/operational need but has risks, gaps, or only partial impact.	Consider the proposal in a wider context. Escalate to Directorate/Exec for review or Directors may escalate to Executive Committee. Decide at Director level within financial delegation (Table 1) to progress or abandon.
31–45	High Priority	Proposal strongly aligns with strategy, addresses key risks, and/or shows major value. Some challenges may remain.	Progress decision to the final level within financial delegation (Table 1) and to the appropriate meeting route.

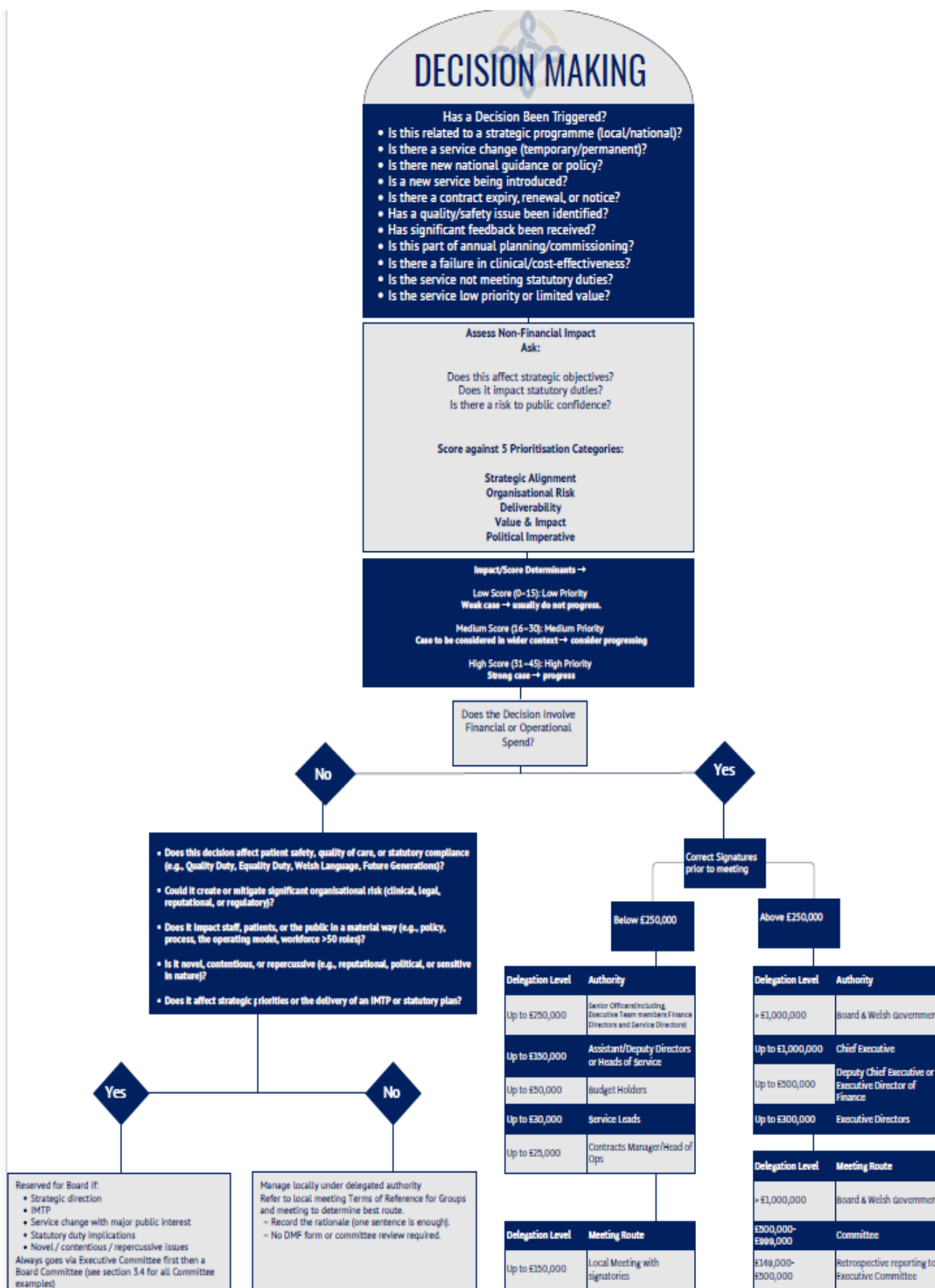
3.4 Governance & Meeting Structure

It is essential that each case is submitted to the correct forum, in line with the SoRD financial thresholds (Tables 3 and 4), and be informed by the prioritisation scoring. This

ensures cases are rationalised, reviewed at the right level, and avoids duplication or delay. Guidance on which meetings and committees consider which types of cases is set out in detail within the procedures with accompanying examples. If there is any uncertainty, colleagues should seek advice from the Corporate Governance team to confirm the appropriate route.

Refer to the Operational Governance Framework for the full breakdown of meeting scope, what decisions should be made in the respective committee and examples. If support is required please contact the Corporate Governance Directorate.

3.5 Decision Making and Prioritisation Flow Chart



3.6 Service Change

A service change includes any proposed change to the type or range of services provided, the location from which services are delivered, or the way in which care is delivered. All proposed service changes must be considered in accordance with the Health Board's service change protocol located [here](#). Colleagues should seek advice from the Strategy and Planning Team at BCU.StrategicPlanningPan@wales.nhs.uk at the earliest opportunity to determine the appropriate classification, governance route, approval requirements, and any engagement or consultation obligations.

Substantial service changes are matters reserved to the Board and would not normally be approved through delegated authority.

4. Integration with Procurement

The Decision Making and Prioritisation Framework must be read in conjunction with the [All-Wales Procurement Manual](#), [Standing Financial Instructions \(SFIs\)](#), and [Schedule of Reservation and Delegation \(SoRD\)](#). All decisions that involve committing public money must follow the prioritisation scoring and comply with procurement law and process

Alignment with the procurement manual is outlined in further detail in the procedures.

5. Statutory Duties in Decision Making

All decisions made by, or on behalf of, the Health Board must comply with the statutory duties that apply to NHS organisations in Wales. These duties ensure decisions are lawful, evidence-based, transparent, and consistent with national legislation and policy. Appendix 3 contains a summary of the key statutory duties.

All decisions must demonstrate:

- Quality and outcomes improve health, safety and patient outcomes
- Equity and rights fair access, equality and human rights
- Sustainability and prevention long-term impact and prevention
- Engagement and partnership involvement of patients and partners
- Compliance and governance meet legal, data, safety and transparency requirements.
- Decision-makers should check and confirm that each relevant duty has been considered and evidenced within the paper or business case, with supporting tools such as the Equality Impact Assessment (EqIA), Quality Impact Assessment (QIA), Health Impact Assessment (HIA), Data Protection Impact Assessment (DPIA), and documented evidence of consultation or engagement.

6. Legal Advice

Where decisions are, or may become, contentious, novel, or subject to legal challenge early legal advice should be sought from the BCUHB legal team. This includes proposed service changes, contractual disputes, partnership arrangements, or decisions with potential statutory or reputational implications. Securing timely legal input supports sound governance, compliance with statutory duties, and appropriate escalation through the Framework.

7. Conclusion

The Health Board's Decision-Making and Prioritisation Framework provides a structured yet flexible approach to decision-making, ensuring that resource allocation is aligned with strategic priorities, best value and Value Based Health Care principles.

By maintaining a consistent, transparent and reviewable prioritisation process, the Health Board can ensure that decision-making quality improves, is evidence-based and data led, ensures value for money and aligned with its overarching objectives to improve health outcomes for its population.

Appendix

Appendix 1 Glossary

Discretionary Capital: is the Health Board's annual locally controlled capital allocation from Welsh Government. It is used to fund small and medium-sized projects that are not part of national or major all-Wales capital programmes; local annual allocation for small/medium projects (delegated approvals up to £1m). *As opposed to General Capital (or "Main Programme") which refers to major capital schemes funded directly by Welsh Government. These are usually large-scale, strategic projects that go beyond the scope of the Health Board's local discretionary allocation; national funding for major strategic projects, always requiring Welsh Government approval.*

Full Business Case (FBC): Confirms affordability, value for money, and readiness for implementation, leading to final approval.

Losses and Special Payments: Payments made outside normal business (e.g., ex gratia, clinical negligence settlements). Approval thresholds are set out in the SoRD.

Outline Business Case (OBC): Provides detailed appraisal of the preferred option, including costs, benefits, and delivery plans.

Scheme of Reservation and Delegation (SoRD): The document setting out which decisions are reserved for the Board and which are delegated to committees or officers.

Standing Financial Instructions (SFI): The detailed financial rules of the Health Board, aligned to the SoRD, covering procurement, contracts, payments, and audit.

Standing Orders (SO): Rules of procedure for how the Board conducts its business, including urgent "Chair's Action."."

Strategic Outline Case (SOC): Establishes the need for investment, outlines options, and secures initial agreement to proceed.

Virement: The transfer of funds between budget headings. Approval thresholds are defined in the SoRD.

Appendix 2 Health Board's Risk Appetite 2025/2026

Quality Risk: There was willingness to be 'open' and consider all potential delivery options and choose while also providing an acceptable level of reward (and Value for Money VfM). We are prepared to accept the possibility of short-term, managed risks to quality or safety where there is strong evidence that the change will deliver long-term improvement in patient outcomes. We will embed investigation and learning into all decisions, ensuring the duty of candour remains central to our approach. **Risks to be tolerated below a score of <15**

Financial Risk: There was an agreed consensus on an 'open' appetite and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). There was an agreed consensus to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated to capitalise on opportunities. **Risks to be tolerated below a score of <15**

Regulatory/Compliance Risk: There was an agreed consensus supporting an 'open' risk appetite to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). Challenge would be problematic, but we are likely to realise a benefit, and the gain will outweigh the adverse consequences. **Risks to be tolerated below a score of <15**

Reputational Risk: There was an agreed consensus to 'seek' some reputational risks and an eagerness to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). We are willing to take bold decisions that may attract significant scrutiny if they are in the best interests of patient safety and service improvement. Reputation is actively managed through transparent, values-based communication, and we view public interest as an opportunity to demonstrate leadership. **Risks to be tolerated below a score of <20**

Innovation Risk: There was a clear consensus to 'seek' innovation, with eagerness to be forward-thinking and to pursue options offering potentially higher business rewards. We actively pursue innovations that challenge current practice while implementing controls to minimise risks to patient safety, where there is strong potential for substantial improvement in outcomes. Controlled trials, pilot programmes, and transparent stakeholder engagement remain integral to this approach. **Risks to be tolerated below a score of <20**

Score tolerances are communicated for each risk domain, and risks should be managed throughout the Health Board in line with domain scores.

Appendix 3 - Summary of Key Statutory Duties

Key Statutory Duty 1: NHS (Wales) Act 2006

- Establishes NHS Wales and its purpose.
- Ensures services improve health, prevent illness, and provide comprehensive care.
- Decisions must align with improving patient outcomes and ensuring equitable access to services.

Key Statutory Duty 2: Well-being of Future Generations (Wales) Act 2015

- Promotes sustainable development across public services.
- Decisions should consider:
 - o **Long-term impact** – how actions affect future generations.
 - o **Prevention** – preventing problems before they occur.
 - o **Integration** – how decisions fit with other services and objectives.
 - o **Collaboration** – working with partners to achieve better outcomes.
 - o **Involvement** – engaging stakeholders and communities.

Key Statutory Duty 3a: Equality Act 2010 Section 149 - (Public Sector Equality Duty)

Decision makers must have 'due regard' to the need to

- eliminate unlawful discrimination, harassment and victimisation
- to advance equality of opportunity
- foster good relations between people who share protected characteristics and those who do not.

The duty cannot be delegated. Integrated Equality Impact Assessment should be completed to evidence how due regard has been discharged and attached to decision papers. Link for support is linked [here](#):

Key Statutory Duty 3b: Equality Act 2010 Pt 1-3 - Socio-economic Duty

This Duty requires decision makers to have due regard to identify and address adverse impacts (for strategic decisions) for people and communities of place and interest who face socio economic disadvantage. Integrated Equality Impact Assessment should be completed to evidence how due regard has been discharged. Link for support is linked [here](#):

Key Statutory Duty 4: Social Services and Well-being (Wales) Act 2014

- Promotes the well-being of individuals requiring care and support.
- Encourages partnership working between health, social care, and third-sector organisations.
- Decisions affecting care delivery must involve patients, service users, and partner organisations.
- Supports co-production and ensures services are person-centred and integrated.

Key Statutory Duty 5: Welsh Language (Wales) Measure 2011

- Requires NHS organisations to treat Welsh and English equally in service delivery where standards apply.
- Decisions must consider the impact on Welsh language services and ensure compliance with the Welsh Language Standards.

- Includes communication with patients, staff, and stakeholders in both languages where relevant.

Key Statutory Duty 6: Human Rights Act 1998

- Requires NHS organisations to act compatibly with the European Convention on Human Rights (ECHR).
- Decisions must respect individuals' rights such as privacy, freedom of expression, and non-discrimination.
- Any interference with rights must be necessary, proportionate, and justified.
- Consider human rights implications for patients, staff, and the public in all significant decisions.

Key Statutory Duty 7: Health and Safety at Work etc. Act 1974

- Ensures the health, safety, and welfare of staff, patients, and visitors.
- Decisions must include risk assessments and measures to mitigate hazards.
- Applies to all operational, estates, and service-delivery changes.
- Supports a safe working and care environment, reducing accidents and incidents.

Key Statutory Duty 8: Data Protection Act 2018 / UK GDPR

- Requires lawful, fair, and transparent processing of personal data.
- Protects the privacy of patients, staff, and other stakeholders.
- Decisions involving personal or sensitive data should include a Data Protection Impact Assessment (DPIA) where appropriate.
- Ensures compliance with data security, retention, and sharing requirements.

Key Statutory Duty 9: Freedom of Information Act 2000

- Promotes transparency and accountability by allowing access to recorded information.
- Decisions and the reasoning behind them should be clearly documented to support requests.
- Ensures the organisation meets its obligations to provide information to the public where required.

Key Statutory Duty 10: NHS (Wales) Quality and Engagement Act 2020

- Promotes continuous quality improvement across NHS services.
- Requires engagement with patients, staff, and stakeholders in decision-making.
- Decisions should be supported by evidence of consultation, feedback, and improvement actions.
- Encourages a culture of learning, accountability, and service excellence.

Key Statutory Duty 11: Public Health (Wales) Act 2017

- Protects and improves population health and addresses health inequalities.
- Decisions should consider public-health impacts, including prevention and promotion of well-being.
- Supports evidence-based interventions to reduce risks to communities.
- Ensures collaboration with partners to improve health outcomes at a population level.

References

The primary references relied upon when developing the framework are as follows:

Welsh Government. (2023). *Health and Care Quality Standards 2023*. Cardiff: Welsh Government. Available at: <https://www.gov.wales/health-and-care-quality-standards-2023>.

Welsh Government. (2023). *Duty of Quality Statutory Guidance 2023*. Cardiff: Welsh Government. Available at: <https://www.gov.wales/duty-of-quality-statutory-guidance-2023>.

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Axelos. (2021). *Management of Portfolios (MoP)*. London: Axelos. Available at: <https://www.axelos.com/mop>.

National Institute for Health and Care Excellence (NICE). (2022). *Developing NICE guidelines: the manual*. London: NICE. Available at: <https://www.nice.org.uk/process/pmg20>.

Austin, D., Edmundson-Jones, P. and Sidhu, K. (2007) 'Priority setting and the Portsmouth scorecard: prioritising public health services: threats and opportunities.' *Health Services 2007 Conference*.

Other NHS Frameworks and sources:

Birmingham and Solihull ICB Prioritisation Framework

Hertfordshire and West Essex ICB Prioritisation Framework

Staffordshire and Stoke ICB Policy on the Prioritisation of HealthCare Resources

OPERATIONAL GOVERNANCE ARRANGEMENTS



Author & Title	Phil Meakin Associate Director of Governance		
Responsible Department / Director:	Corporate Governance Pam Wenger Director of Corporate Governance		
Approved by:	Executive Committee 15 July 2026		
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Documents to be read alongside this document:	BCUHB Decision Making Framework Scheme of Reservation & Delegation (SoRD) Standing Financial Instructions (SFIs) BCUHB Integrated Planning Framework BCUHB Integrated Performance Framework BCUHB Risk Management Framework BCUHB Values and Behaviours BCUHB Design Principles All Wales Procure to Pay e-Manual for use by Health Organisation Colleagues Direct Awards Against a Framework Agreement		
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Please avoid printing this document – this protects the environment whilst also reducing the risk of out-of-date printed versions of the document.

The BCUHB Intranet should be referred to for the most current version of the document and relevant references.

Contents

1.Introduction	4
2. Summary of Health Board Corporate Governance	4
3. Summary of Service Group Corporate Governance	5
4.Supporting the Discharge of Service Group Corporate Governance Responsibilities	9
5.Discharging Service Group Decision Making, Reporting and Escalation	10
6. Triumvirate Leadership Responsibilities	12
7. Risk Management - Duties of Service Groups	13
8. Key Governance Competencies and Assessment for Service Groups	13
9. Appendices and Supporting Information	14
Appendix 1. Summary of Health Board Corporate Governance	15
Appendix 2. Triumvirate Leadership Responsibilities	16
Appendix 3. Decision Making Framework Summary (Link to full framework) and Example Decisions and Delegation	20

1.Introduction

1.1. Purpose and Context

These arrangements provide requirements, guidance and support to Service Groups (proposed in the new operating model) in the discharge of operational governance responsibilities. The document also provides requirements, guidance and support for all Health Board Services (which are not yet in scope of the proposed operating model) to discharge operational governance responsibilities.

1.2 Objectives and Key Principles Informing the Operational Governance Arrangements

This document operates on the following objectives:

- Clear lines of decision-making, assurance and accountability for all Service Groups
- Developing proportionate, purposeful Service Group meetings that avoid duplication and focus on quality and safety, performance management, financial management, risk management and regulatory compliance and actions
- Timely escalation of risks, issues and decisions to the appropriate level
- Alignment with existing health board frameworks

Table 1 – Key Principles Informing the Operational Governance Arrangements

Key Principle	Summary
Clarity on the status of the Operational Governance Framework	This framework is complimentary to the approved Health Board Governance and Accountability Framework and associated frameworks. It is not an integrated Governance Framework. It focuses on
Adhering to Health Board Governance Tiers	The governance Tiers agreed by the Health Board are utilised in this framework to ensure consistency. (See section 2)
Clarity on core and defined autonomy operational governance requirements	There are prescribed core requirements that Service Groups must adhere to in discharge of their Governance responsibilities. There is also a degree of delegated autonomy to discharge Service Group governance responsibilities. (See section 3.2)
Health Board decision making guidance	The importance of providing clarity and linking to the Health Board Decision-Making framework (See section 5)
Engagement of senior Service Leaders in development of this framework	Executive Committee required engagement with senior Service leads in the development of this framework, and ongoing development of the tools to develop it.
Support to enable the implementation and maturing of the Operational Governance Framework.	Practical support is provided as part of this framework to enable consistency across the Health Board and assessment of implementation. (See section 8)

2. Summary of Health Board Corporate Governance

The Health Board has approved a Governance and Accountability Framework for the Health Board which contains the Standing Orders of the Health Board and related frameworks, including the Standing Financial Instructions. Links to which are provided in this framework. As part of this framework there are four agreed

Tiers for Corporate Governance for the Health Board. Table 2 outlines the four tiers (Tier 0, Tier1, Tier 2, Tier 3) and a full map of Health Board service corporate governance is set out in Appendix 1.

Table 2 – Outline of the Tiers of health board governance

Tier	Description	Summary of Corporate Governance Tier
Tier 0	The Health Board	-Accountable for setting the organisation's strategic direction, ensuring that effective governance and risk management arrangements are in place and holding Executive Directors to account for the effective delivery of its Annual Delivery Plan.
Tier 1	Health Board Committees	-Undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. Focusses on matters of greatest risk that would prevent the health board from meeting its vision, aims and objectives.
	Executive Committee	-The Health Board's primary executive decision-making forum, supporting the Chief Executive in the oversight of day-to-day management, including governance, risk management and internal control arrangements, in line with delegated authority from the Board.
	Executive Delivery Groups	-Provide focused, executive-led oversight of core areas of delivery, including planning, performance, workforce, quality, commissioning and regulatory compliance. -Support the Executive Committee (EC) by ensuring that proposals are fully developed, evidence-based and subject to appropriate scrutiny before being brought forward for strategic decision-making.
Tier 2	Portfolio-led groups established by Executive Directors	-Portfolio-led groups established by Executive Directors to oversee their delegated responsibilities and to contribute and provide assurance to the Board and Tier 1 arrangements in terms of the delivery of structures, processes and plans to deliver the health board's statutory obligations and strategic objectives. (examples include the Operational Leadership Group and Risk Scrutiny Group)
Tier 3	Operational Leadership Governance	-Operational decision making within delegated authority -Accountability for performance, quality and safety -Integration of core governance -Adherence to the Corporate Governance Framework -Escalation and reporting into wider governance system -Delivery of Strategic Intent -Local Leadership and Culture -Triumvirate Leadership responsibilities

This document is focussed on Tier 3 (Operational Leadership Governance) and how it relates to the tiers above it. A summary of Health Board Governance from Tier 0 to Tier 3 is provided in Appendix 1.

3. Summary of Service Group Corporate Governance

This section defines the requirements of Service Groups in the discharge of Service governance responsibilities.

3.1 Core Requirements in Discharging Service Group Governance

Service Groups have a responsibility for operational control and are the Health Board's "first line of defence." Day-to-day operational decisions (e.g. activity changes, staffing responses, immediate quality actions) sit with Service Groups. They operate with defined autonomy, but within Board-approved limits that are set out in the Schedule of Reservation and Delegation and Standing Financial Instructions (SORD/SFIs). Decisions outside that authority must be escalated.

Service Groups must adhere consistently with governance related Health Board frameworks, and these are noted in Section 9 below. Service Groups are also responsible for integrating core governance requirements and must also demonstrate effective governance across all these key domains (outlined in Table 2 below).

The Health Board's Governance Framework supports not only the delivery of safe, effective and high-quality healthcare services, but also the wider responsibilities of the organisation as a commissioner, system leader and steward of population health.

Governance arrangements at every level should ensure that decisions are informed by quality, safety, performance, commissioning requirements and population health intelligence, with consideration of prevention, early intervention, health inequalities and value-based healthcare. Service Groups, Triumvirates and Corporate Groups are expected to contribute to the delivery of commissioned services, improve outcomes for local populations, and ensure that operational decisions support the long-term health and wellbeing of communities alongside the effective delivery of current services.

This approach strengthens the Health Board's ability to deliver person-centred care, reduce inequalities, maximise value from public resources and improve health outcomes for the population it serves.

3.2 Delegated Autonomy in Discharging Service Group Governance Responsibilities

The arrangements also clarify where Service Groups have delegated autonomy to discharge their governance responsibilities. This enables Service Group leaders to design and operate governance arrangements that are proportionate to the needs of the Service, while remaining aligned to the requirements of the Health Board. Any proposed changes to Service Group governance arrangements must be reviewed by the Corporate Governance Directorate to provide assurance that they remain consistent with the principles, standards and accountability requirements set out within these arrangements. Table 2 sets out the Service Group operational governance requirements.

Table 2 – Checklist of Operational Governance - Core and Defined Autonomy

No	Requirement Check List	Core Requirement	Defined Autonomy
1	<p>Establish a Service Leadership Team (with a Health Board approved Terms of Reference, agenda format, reporting, minutes and escalation templates) that has;</p> <ul style="list-style-type: none"> -Accountability for governance within the Service Group -Responsibility for embedding consistent behaviours, standards and culture <p>Service Groups Leadership Teams must escalate risks, decisions and exceptions to Tier 1 (e.g. Executive Committee, Executive Delivery Groups) and Tier 2 (e.g. Operational Leadership Team/Pan Betsi Quality and Safety Groups) by using structured reporting using standardised formats (ToR, agendas, minutes, reporting).</p>	✓	
2	<p>Establish a Service Quality, Safety and Experience Group that reports into the Service Leadership Team (with a health board approved Terms of Reference, agenda format, reporting, minutes and escalation templates)</p> <ul style="list-style-type: none"> -The Service Quality, Safety and Experience Group must also escalate risks, decisions and exceptions to the Service Leadership Team by using structured reporting using standardised formats (ToR, agendas, minutes, reporting, risk registers). <p>(A guide to the Current Quality Management System and Governance landscape for patient safety is provided in Section 9)</p>	✓	
3	<p>Establish Service Groups for defined integrated governance (with a Health Board approved Terms of Reference, agenda format, reporting, minutes and escalation templates) to discharge the following responsibilities;</p> <ul style="list-style-type: none"> -Performance management -Financial management and planning -Risk management (<u>aligned to Risk Management Framework</u>) -Regulatory compliance and actions (including Health and Safety related to services) -Workforce and culture (including workforce Health and Safety) -Transformation and major programmes -Information governance -Education -Research <p>The Service Groups established must escalate risks, decisions and exceptions to the Service Leadership Team by using structured reporting using standardised formats (ToR, agendas, minutes, reporting, risk registers).</p>		✓
4	<p>Effective Triumvirate Leadership</p> <p>Within the Operational Governance arrangements, the triumvirate acts as the primary vehicle through which operational governance requirements are integrated into day-to-day decision-making. These arrangements require Service Groups to adhere to the requirements set out in the appendix. Specifically, the following areas of operational governance focus are:</p> <ul style="list-style-type: none"> • Quality and Safety • Risk and Assurance • Workforce and culture • Performance and Resources • Medicines Management and Medicines Governance • Leadership behaviours and role modelling • Providing assurance <p>Service Groups have delegated autonomy to establish internal arrangements to support and enable effective triumvirate leadership.</p>	✓	✓
5	<p>Adherence to the Health Board frameworks and plans including;</p> <ul style="list-style-type: none"> • BCUHB Decision Making Framework • <u>Scheme of Reservation & Delegation (SoRD)</u> 	✓	

	<ul style="list-style-type: none"> • Standing Financial Instructions (SFIs) • BCUHB Integrated Planning Framework • BCUHB Integrated Performance Framework • BCUHB Risk Management Framework • BCUHB Values and Behaviours • BCUHB Design Principles • All Wales Procure to Pay e-Manual for use by Health Organisation Colleagues • Direct Awards Against a Framework Agreement • Integrated Medium Term Plan (IMTP) and Annual Delivery Plan 		
6	Ensure operational decision making within delegated authority -Day-to-day operational decisions (e.g. activity changes, staffing responses, immediate quality actions) sit with Service Groups. Operating with defined autonomy, but within Board-approved limits (SORD/SFIs). Decisions outside that authority must be escalated to the next appropriate tier of governance.	✓	
7	Ensure that individual services and functions that are part of the Service Group have effective governance arrangements by which risks, decision and exceptions can be reported. -Ensuring that pan health board functions such as Pharmacy, Therapies and Health Sciences are considered in Service Group governance arrangements -Service Groups can establish internal arrangements to support these arrangements by establishing Service Group Directors networks and internal performance review mechanisms.	✓	✓
8	Delivery of Strategic Intent Service Groups ensure that governance arrangements include consideration of progressing -IMTP priorities -Annual Delivery Plan -Transformation programmes -Major Change Programmes	✓	
9	Service Group attendance at Operational Leadership Group and Tier 2 meetings -Ensure senior Service Group attendance at each Operational Leadership Group meeting -Ensure senior Service Group attendance at the appropriate Tier 2* (see note below) and Tier 1 group meetings. (in line with those Groups Terms of Reference)	✓	
10	Undertake training and development on the Health Board corporate governance arrangements prior to the establishment of Service Groups and once they have been established.	✓	
11	Bi-Annual Self-Assessment of Operational Governance requirements using the Health Board Corporate Governance and Quality and Safety Maturity Matrix. See section 9.	✓	
12	Management of regulatory recommendations and associated actions , including Internal Audit and regulatory recommendations -Ensure that governance arrangements are in place to progress the effective management of responses	✓	
13	Consideration of Directors Accountability arrangements	✓	
14	Consideration of Chief Executive Performance Review criteria	✓	
15	Consideration of responses to Welsh Government Escalation and “Well Led Reviews” -Ensuring that resources are available to respond to Escalation and well-led reviews are established in the Service Group	✓	

	-Providing information to support the assessment of Escalation and well-led criteria to Health Board and Welsh Government as required.		
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*During the implementation of these arrangements a mapping of all Tier 2 Groups will take place in consultation with Executive Directors.

3.3 Linking to Tier 2 Governance Groups

Tier 2 groups are pan Health Board portfolio-led groups established by Executive Directors to oversee their delegated responsibilities and to provide assurance to the Board and Tier 1 arrangements in terms of planning, performance, workforce, quality, commissioning and regulatory compliance.

As part of the phased implementation of these arrangements, all Tier 2 groups are being reviewed and mapped with Executive Team colleagues. The intention is to streamline governance arrangements, reduce unnecessary complexity and eliminate duplication of responsibilities, reporting and membership across Groups. This work will support a more efficient governance structure, with clear accountability, defined decision-making responsibilities and effective escalation routes. The Corporate Governance Directorate can provide support and assurance advice to Directorates and Service Groups while this work is being undertaken.

Operational Leadership Group is a Tier 2 group and the Service Group Senior Leadership Teams will make reports to this Group. A Terms of Reference is provided for this Group in the appendices. The Group allows the triangulation of important decisions and information from services.

Other Tier 2 Groups have a pan Health Board responsibility in the discharge of Executive Directors portfolios. The relationship between Tier 3 (Operational Leadership Governance) and Tier 2 groups is important as it allows for the two way flow of governance and information. This will include the development and sharing of health board policies, protocols and guidance that will inform the discharge of governance responsibilities in Service Groups and Executive Delivery Groups, and incorporates the important contribution of professional groups and health board expertise.

4.Supporting the Discharge of Service Group Corporate Governance Responsibilities

The Corporate Governance Directorate will support Service Groups and Services in the implementation of these arrangements. Table 3 summarises the support that is available.

Table 3 – Summary of Support Provided to Service Groups

Corporate Governance Support	Expertise Support
<ul style="list-style-type: none"> • Common Terms of Reference for all governance Groups identified in these arrangements and approved by Health Board • Common agenda, minutes and reporting formats • Common cycle of business and corporate calendar format • Up to date Health Board frameworks available and updated in one document 	<ul style="list-style-type: none"> • Support and training from Corporate Governance Directorate to help lead the final development, engagement and embedding of the framework • Lead and embed the development of an internal “Community of Governance Practice” with governance colleagues from Services • Development of Corporate Governance and Quality and Clinical Governance Maturity Matrix to support self-assessment against requirements. • Interpretation and on-going development of the Decision-Making Framework for Service Groups • Supporting the Health Board to ensure compliance against these arrangements • Providing the support in the provision of guidance and information on the Welsh Government Escalation and “Well led” requirements

5. Discharging Service Group Decision Making, Reporting and Escalation

The Decision Making Framework (DMF) ensures the Health Board has a single, consistent, and transparent approach to prioritisation and decision-making. It aligns with the Governance and Accountability Framework ([incorporating the Scheme of Reservation and Delegation \(SoRD\)](#), [Standing Financial Instructions \(SFI\)](#) and [Welsh Government requirements](#)), and should be read in conjunction with these documents to ensure compliance. A summary of the Decision Making Framework and the full framework is provided in this link is provided in Section 9. The decision flow diagram is provided in Appendix 3 with examples of decisions and delegation arrangements.

Given the wide range of responsibilities and services within the Health Board, there is no single universal prioritisation approach that would meet every case. The Decision Making Framework exists as a foundational standard, allowing others to adapt and build upon its core components. It is a requirement of this Operational Governance arrangements to comply with the Decision Making Framework and seek support from the Corporate Governance Directorate where additional guidance is needed.

5.1 Decision Making and Delegated Authority

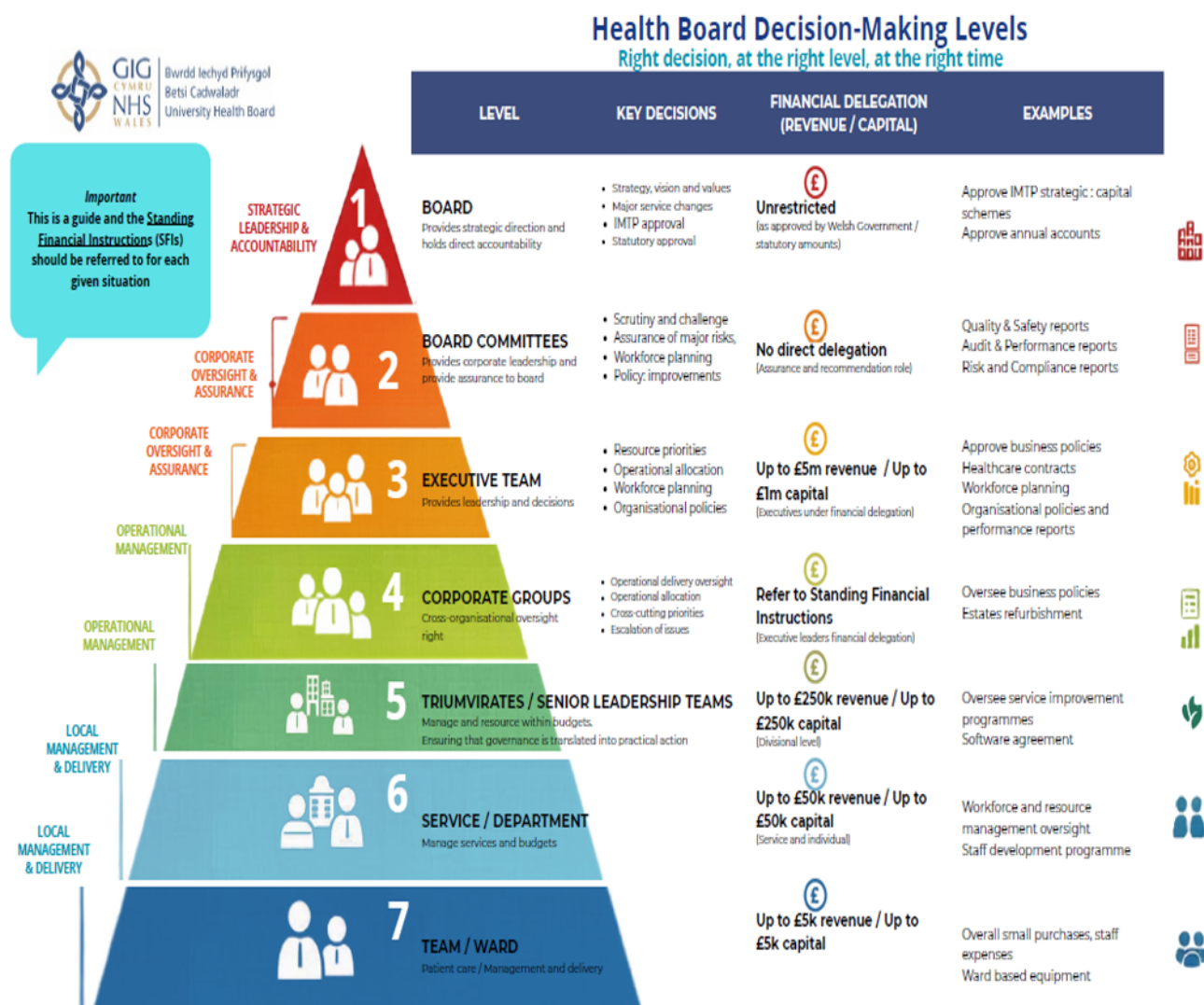
Operational decision making facilitates service delivery and is also the opportunity for effective operational control. **Operational decision making must take place within delegated authority.**

Day-to-day operational decisions (e.g. activity changes, staffing responses, immediate quality actions) sit with Service Groups. Service Groups operate with **defined autonomy**, but **within Board-approved limits in accordance with the (SORD/SFIs)**. Decisions outside that authority must be escalated. If there are Service Group decisions that are required outside of its delegated authority then it should be escalated to the appropriate Corporate Governance Group. The summary of questions in Table 4 is a useful guide to initiate effective decision making. Table 5 provides a pictorial guide to delegated authority. It is important to not that the examples used are a guide and the Standing Financial Instructions (SFI) set out delegation in the level of detail required each type of decision.

Table 4 - Summary of Service Group Questions to Support Effective Decision Making

No	Question to Support Effective Decision-Making	Yes	No
1	Is this decision delegated to my Service or me under the Health Board Standing Orders?	Proceed	Escalate to Group/Director that can make that decision
2	Do I have the delegated authority to approve this decision?	Proceed	
3	Do I have an approved budget by which to enable the approval of this decision?	Proceed	
4	Is the decision purely related to my Service	Proceed	
5	If the decision impacts on other Services and/or Pan Betsi	If outside of delegation, authority and service then escalate to group that can make that decision	

Table 5 - Summary of Delegated Authority in the Health Board



6. Triumvirate Leadership Responsibilities

The Health Board's operating model is founded on effective triumvirate leadership, bringing together clinical, nursing and operational leaders to provide collective accountability for the delivery of safe, effective, person-centred and sustainable services.

The triumvirate is also responsible for ensuring compliance with quality, operational, workforce and financial standards whilst providing leadership for continuous improvement and service development. Within the Operational Governance arrangements, the triumvirate acts as the primary vehicle through which quality, safety, performance, workforce, risk and financial stewardship are integrated into day-to-day decision-

making. Appendix 2 contains a summary of “Triumvirate Leadership Responsibilities” which covers principles, core responsibilities and operational governance arrangements.

The triumvirate therefore provides the critical link between frontline service delivery and Board assurance, ensuring that governance is translated into practical action and that operational decisions consistently support the Health Board’s Duty of Quality and commitment to continuous improvement.

7. Risk Management - Duties of Service Groups

Summary of Risk Management arrangements are provided in the [Risk Management Framework](#). Services are required to nominate a risk lead/champion on behalf of the Service to ensure the Service risk register is well maintained and risk is championed throughout the Service facilitating good identification processes.

Service risk leads will support the operational management of their respective service risk register and will liaise with the corporate Risk Management Team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

Risk Management must be a standing item on the agenda of every Service Group SLT and Service Group meetings agenda.

8. Key Governance Competencies and Assessment for Service Groups

These arrangements requires Service Group leaders to be aware of and develop core governance competencies requirement for 1. Corporate governance and decision making 2. Risk management and statutory compliance and 3. Legal awareness. A competency framework (link in Section 9) has been developed that contains;

- Required Service Group governance competencies, description and expectations
- Support to develop these governance competencies through training and support.
- Corporate Governance and Quality and Safety maturity matrix

Service Group Senior Leadership Teams will be required to undertake an assessment against these competencies aided by a Corporate Governance maturity matrix and a Quality and Safety Maturity Matrix bi-annually with the oversight and support of the Corporate Governance Directorate.

9. Appendices and Supporting Information

Appendices

- Appendix 1 – Summary of Health Board Operational (Service) Governance
- Appendix 2 – Triumvirate Leadership responsibilities
- Appendix 3 – Decision Making Framework Summary

Supporting Information

- Links to Terms of Reference to be used as a template all Service Group Governance Groups identified in these arrangements (under development)
- Links to agenda, minutes and reporting formats to be used as a template for all Service Group Governance groups (under development)
- Links to Common cycle of business and corporate calendar format for all Service Group Governance groups (under development)
- [Links to FFtF Governance Core Competency Framework \(link\)](#)
- [Link to Corporate Governance and Quality and Safety Maturity Matrix \(link\)](#)
- Links to Health Board frameworks available
 - [BCUHB Decision Making Framework](#)
 - [Scheme of Reservation & Delegation \(SoRD\)](#)
 - [Standing Financial Instructions \(SFIs\)](#)
 - [BCUHB Integrated Planning Framework](#)
 - [BCUHB Integrated Performance Framework](#)
 - [BCUHB Risk Management Framework](#)
 - [BCUHB Values and Behaviours](#)
 - [BCUHB Design Principles](#)
 - [All Wales Procure to Pay e-Manual for use by Health Organisation Colleagues](#)
 - [Direct Awards Against a Framework Agreement](#)

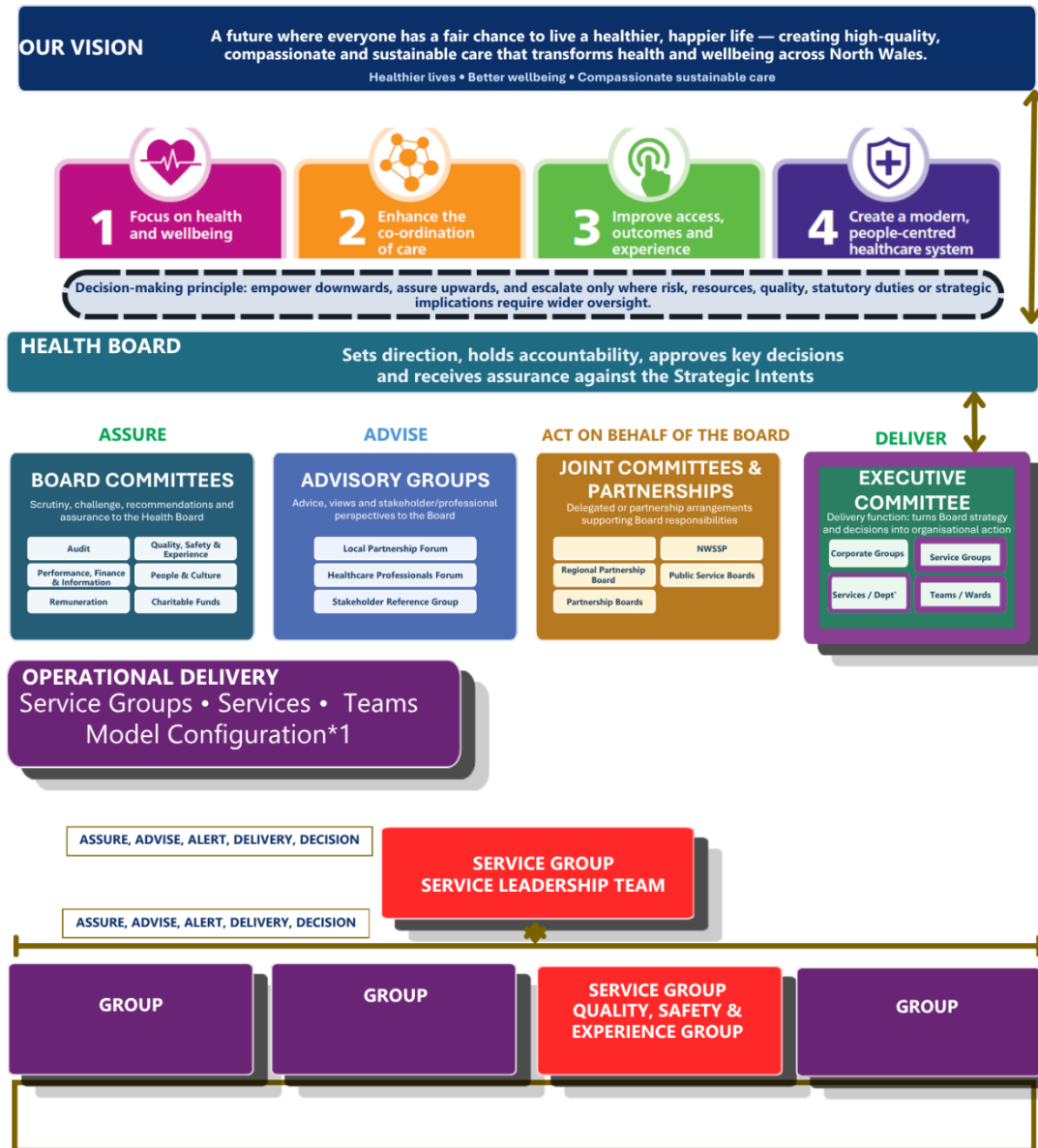
Appendix 1. Summary of Health Board Corporate Governance



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Governance Supporting Delivery of the Health Board Vision and Strategic Intent

A SINGLE LINE OF SIGHT: VISION, TO STRATEGIC INTENT, TO ASSURANCE, ADVICE, DELEGATED OVERSIGHT AND EXECUTIVE DELIVERY



Appendix 2. Triumvirate Leadership Responsibilities

The Health Board's operating model is founded on effective triumvirate leadership, bringing together clinical, nursing and operational leaders to provide collective accountability for the delivery of safe, effective, person-centred and sustainable services.

The triumvirate is also responsible for ensuring compliance with quality, operational, workforce and financial standards whilst providing leadership for continuous improvement and service development.

Within the Operational Governance Framework, the triumvirate acts as the primary vehicle through which quality, safety, performance, workforce, risk and financial stewardship are integrated into day-to-day decision-making. Appendix 2 contains a "Triumvirate Leadership Responsibilities," which covers principles, core responsibilities and operational governance arrangements."

The triumvirate therefore provides the critical link between frontline service delivery and Board assurance, ensuring that governance is translated into practical action and that operational decisions consistently support the Health Board's Duty of Quality and commitment to continuous improvement.

Principles

Triumvirate Leadership is underpinned by;

- Collective accountability
- Share decision-making
- Visible leadership
- A culture of openness, learning and improvement
- Strong governance and effective risk management
- A relentless focus on patient outcomes, experience and safety
- Quality is not a separate process or committee function. It is embedded in operational leadership and forms part of every decision taken by the triumvirate.

Core responsibilities:

The triumvirate is responsible for;

- Delivering safe, effective and high quality services.
- Maintaining oversight of quality, safety, workforce performance and finance
- Ensuring compliance with statutory, regulatory and professional standards
- Identifying, managing and escalating risks
- Providing assurance through the governance structure
- Leading service improvement and transformation
- Ensuring lessons from incidents, complaints, audits and reviews are translated into meaningful improvement

Operational Governance Arrangements:

As part of routine operational governance triumvirate teams will have the following responsibilities:

Quality and Safety

- Review quality indicators, patient outcomes and patient experience information
- Monitor incidents, serious incidents, complaints, concerns, claims and mortality reviews
- Identify emerging risks and areas of unwarranted variation
- Ensure improvement actions are implemented and regularly reviewed
- Undertake quality impact assessments for significant operational decisions and service changes

Risk and Assurance

- Maintain oversight of service risk and controls
- Ensure risks are reflected appropriately within the risk management framework
- Monitor delivery of mitigating actions
- Seek assurance through performance data, audits, inspections, patient feedback and staff intelligence
- Escalate concerns where risks exceed local management controls

Workforce and Culture

- Promote a positive safety and improvement culture
- Support staff well-being and engagement
- Encourage staff to raise concerns without fear of blame or reprisal
- Ensure workforce decisions consider quality, safety and patient impact
- Champion multidisciplinary and multi-professional working

Performance and Resources

- Review quality, workforce, activity and financial information a part of a single integrated performance discussion
- Ensure operational pressures and recovery actions do not compromise quality or patient safety
- Balance service performance with sustainable use of resources
- Monitor delivery of operational plans and improvement trajectories

Medicines Management and Medicines Governance

Medicines management forms an integral part of the Operational Governance Framework and is a core responsibility of the triumvirate. The triumvirate must ensure effective arrangements are in place for:

- Medicines safety
- Medicines optimisation
- Safe prescribing and administration
- Antimicrobial stewardship
- Controlled drugs governance
- Medicines reconciliation
- Compliance with medicines legislation, policies and professional standards
- Routine governance should include:
 - Review of medicines related incidents and trends
 - Learning from medication errors and investigations
 - Findings from pharmacy audits and assurance reviews
 - Emerging medicines safety risks
 - Progress against medicines safety risks
 - Progress against medicines optimisation initiatives.

- The triumvirate should work closely with pharmacy teams to ensure management arrangements and that medicines risks are appropriately escalated and managed.

Leadership Behaviours and Role Modelling

The effectiveness of operational governance relies upon the behaviours demonstrated by triumvirate leaders. Triumvirate leaders are expected to:

- Demonstrate visible and authentic leadership
- Model openness, transparency and candour
- Encourage constructive challenge
- Promote accountability at all levels
- Lead by example in complying with governance arrangements
- Foster psychological safety and organisational learning.
- Maintain a focus on improvement rather than blame
- Leaders should routinely engage with teams through ward visits, service reviews, quality walkarounds and staff engagement activity to maintain direct oversight of quality and safety within services.

Providing Assurance

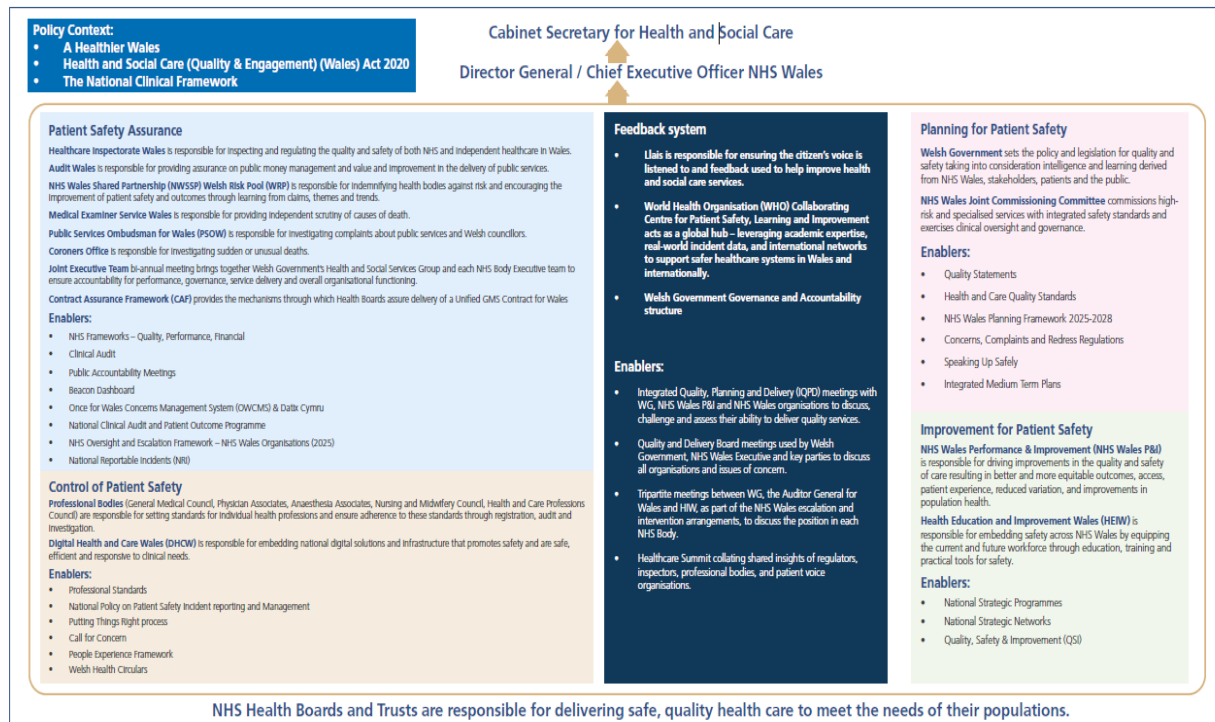
A well-functioning triumvirate should be able to provide clear assurance that :

- Patients receive safe, effective and person-centred care
- Quality risks are understood and actively managed
- Service performance is continually monitored and challenged
- Medicines are used safely and effectively
- Improvement actions are implemented and achieving the intended outcomes

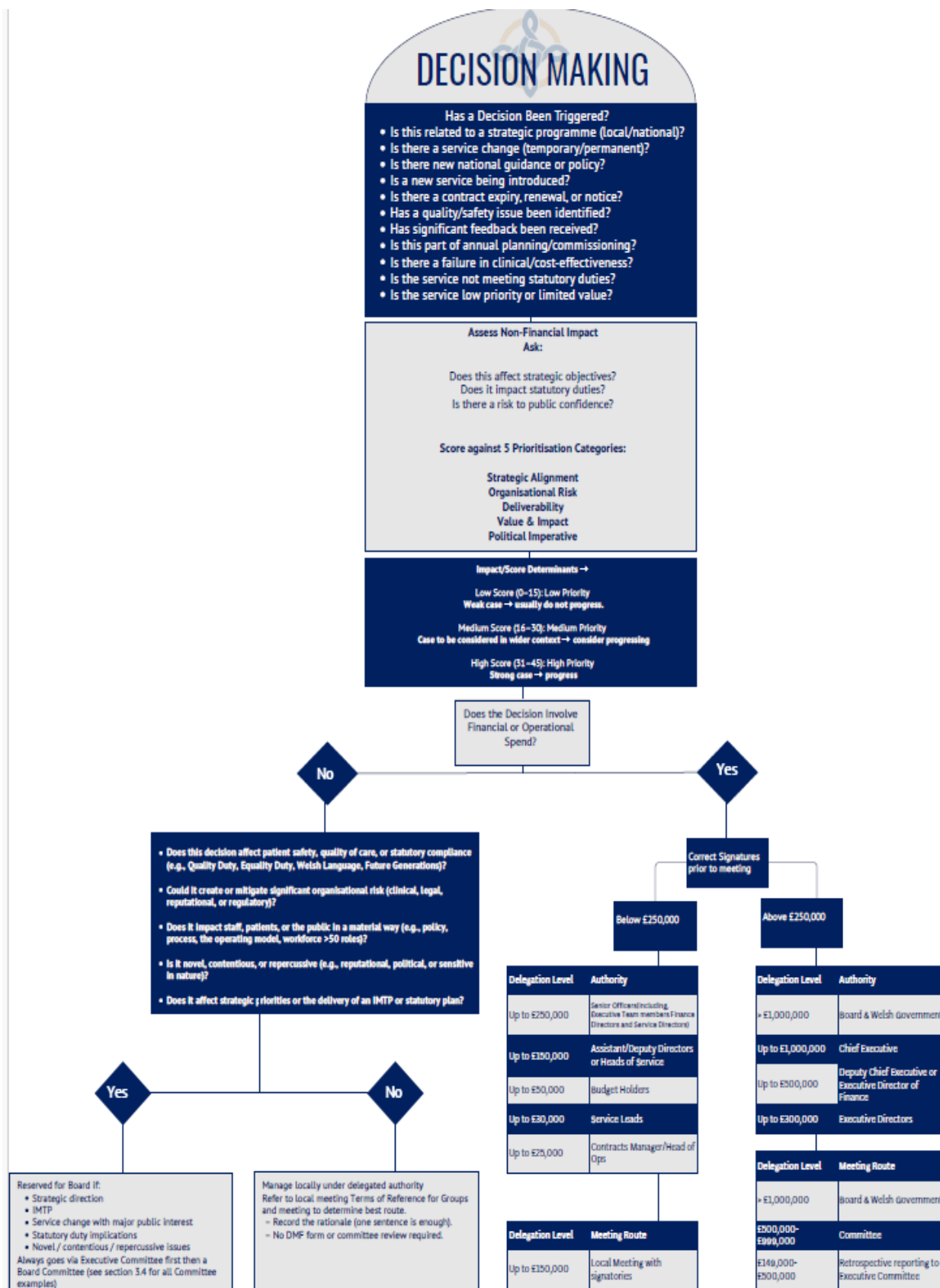
The triumvirate therefore provides the critical link between frontline service delivery and Board assurance, ensuring that governance is translated into practical action and that operational decisions consistently support the Health Board's Duty of Quality and commitment to continuous improvement.

Table 1 below provides a summary of the current QMS and governance landscape for patient safety

Appendix 3: NHS Wales Current QMS and Governance landscape for Patient Safety



Appendix 3. Decision Making Framework Summary (Link to full framework) and Example Decisions and Delegation



AREA	EXAMPLE DECISIONS	ROLE OF CORPORATE LEVEL GOVERNANCE/TEAMS (TIER 2)	ROLE OF SERVICE GROUP GOVERNANCE/TEAM (TIER 3)
Day-to-day operations	Cancel planned activity; open beds temporarily; act after identifying a quality issue	Supports operations; may intervene if performance is below expectations	Autonomy to make daily operational decisions with Health Board support as needed.
Service Changes/Temporary changes	Service changes of a medium to long term nature and temporary closures impacting on services in the shorter term	Sets service priorities and would be overseen by the appropriate Executive Delivery Group. Would need to consider any temporary closures and approve/recommend them. The SORD sets out that such decisions ("introduction or discontinuance of any significant activity or operation") are reserved for the Board	Within the service priorities for the Health Board, the Service Group would develop proposals for the appropriate Executive Delivery Group (including for temporary closures) and for Board to approve
Financial	Budget virements; redundancies; equipment replacement	Sets investment priorities; prevents duplication; sets and monitors budgets if outside of the delegated authority of £250k	Manages local spending priorities within the delegated authority of £250k (with an approved budget allocated to Service Groups).
Workforce	Leadership appointments; consultant hiring; temporary staffing decisions	Develops and nurtures top leadership talent	Manages local workforce needs and challenges



AUDIT, RISK AND ASSURANCE COMMITTEE

ANNUAL REVIEW OF RM01 RISK MANAGEMENT FRAMEWORK

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Jody Evans, Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	Endorse for Board Approval

Crynodeb Gweithredol **Executive Summary**

The annual review of the RM01 Risk Management Framework has been completed to ensure that the Health Board's approach to risk remains aligned with the revised 2026/27 Risk Appetite Framework and the developing governance arrangements for risk reporting, scrutiny and escalation. The revised Framework incorporates the updated risk domains, appetite statements and escalation thresholds approved by the Health Board in September 2026.

The principal change is the transfer of detailed scrutiny and monitoring of Corporate Risk Register and Board Assurance Framework risks to the relevant Executive Delivery Groups. This places accountability, constructive challenge and oversight closer to the Executive leads responsible for managing the risks and delivering the required mitigating actions.

The Risk Scrutiny Group will retain an organisation-wide role, overseeing the effectiveness and maturity of risk management and supporting the development of a stronger risk culture. Its continuing role will be reviewed as the revised



arrangements become established, including consideration of whether the Group remains necessary after the next six months.

Taken together, the changes provide clearer accountability, more direct scrutiny of strategic risks, and strengthened escalation and reporting arrangements. They also support a more integrated line of sight between risk ownership, executive delivery and the assurance provided to Committees and the Health Board.

The Audit Committee is asked to endorse the revised RM01 Risk Management Framework and the associated reporting, scrutiny and escalation arrangements, supporting its submission to the Health Board in November 2026 for final approval.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	Sept 26	Endorsed the proposed Executive Delivery Group reporting arrangements.
Health Board	Sept 26	Updated risk appetite approved.
Executive Committee	Oct 26	Approved the revised Risk Framework including the proposed Executive Delivery Group reporting arrangements and revised risk appetite.

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

ANNUAL REVIEW OF RM01 RISK MANAGEMENT FRAMEWORK

1. Y SEFYLLFA SITUATION

To seek Audit Committee Endorsement and approval of the revised RM01 Risk Management Framework following its annual review. The changes reflect the updated Risk Appetite Framework and revised governance arrangements for risk reporting, scrutiny and escalation.

2. Y CEFNDIR BACKGROUND

The Risk Management Framework provides the overarching structure for identifying, managing, escalating and monitoring risk across the Health Board. Following Board and Executive discussions on risk appetite and governance arrangements, updates are required to ensure the Framework remains aligned to current organisational requirements.

3. MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

Risk Appetite

The Framework has been updated to reflect the revised 2026/27 Risk Appetite (approved by the Board in September 2026), including updated risk domains, appetite statements and escalation thresholds.

Risk Governance Arrangements

It is proposed that:

- o Detailed scrutiny of CRR and BAF risks will be undertaken by the relevant EDGs.
- o EDGs become the primary forum for challenge, oversight and monitoring of strategic risks.
- o The Risk Group provides organisational oversight of risk management effectiveness, risk maturity and risk culture and consideration will be given if the group could be stood down in the next 6 months
- o Escalation and reporting arrangements are amended to reflect the revised governance model.

4. Governance Oversight, Scrutiny and Assurance

During 2026, the Health Board has continued to strengthen its strategic risk management arrangements through implementation of the revised Corporate Risk Register, Executive Committee deep dive reviews of Corporate Risks,

and completion of the annual review of the Risk Appetite Framework. These developments have enhanced risk reporting, executive oversight and organisational assurance arrangements.

The annual review of the RM01 Risk Management Framework incorporates the revised 2026/27 Risk Appetite Framework and updates to risk governance arrangements.

Under the proposed model, Executive Delivery Groups (EDGs) will undertake detailed scrutiny of Corporate Risk Register (CRR) and Board Assurance Framework (BAF) risks, strengthening accountability and challenge closer to risk ownership and delivery.

The Risk Scrutiny Group (RSG) will provide organisational oversight of risk management effectiveness, risk maturity and risk culture, supported by revised reporting and escalation arrangements.

The proposed changes strengthen executive accountability, align risk governance arrangements with organisational delivery structures and support a more integrated approach to risk oversight and assurance across the Health Board.

5. ARGYMHELLION RECOMMENDATIONS

Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **ENDORSE** the updated RM01 Risk Management Framework for submission to the Health Board in November 2026 for final approval
- **NOTE the** incorporation of the revised 2026/27 Risk Appetite Framework.
- **ENDORSE** the revised risk reporting, scrutiny and escalation arrangements through Executive Delivery Groups.

➤ **Appendix 1 – RM01 – Draft Risk Management Framework**



ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
	If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Naddo/No: ☒	
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome:	Naddo/No:
	Do/Yes: Os naddo, dylech gynnwys y rheswm:	N/A



	If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ Administrative Report
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ N/A
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Administrative Report
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol - Nodau Llesiant</u>	A Resilient Wales	



Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Canlyniad/Outcome:	N/A
Data Protection Impact Assessment	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>		
Asesiad o Effaith ar Atal Twyll	Do/Yes: ☐	Naddo/No: ☒
<i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Canlyniad/Outcome:	N/A
Counter Fraud Impact	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
<i>Have you considered the counter fraud impacts</i>		
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

RISK MANAGEMENT FRAMEWORK

2026-29





Updates highlighted in Yellow

Author & Title	Director of Corporate Governance		
	Head of Risk Management		
Responsible Department / Director:	Corporate Governance > Risk Management Chief Executive		
To be Approved by:	Health Board: 26/11/2026 Audit Committee (AC): 20/10/2026 Executive Committee: 07/10/2026		
Date approved:			
Date activated (live):			
Documents to be read alongside this document:	Risk Management Procedures (RM02) Risk Management Training Procedures (RM03) Terms of Reference Risk Scrutiny Group BCUHB Integrated Performance Framework BCUHB Integrated Planning Framework BCUHB Accountability Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy		
Date of next review:			
Date EqIA completed:	December 2025 (Original 2016)		
Date IAST completed:	December 2025		
First Operational:	28 Sept 2023		
Previously reviewed:	Sept 2023	Health Board - 25 July 2024 Audit Committee (AC) - 18 July 2024 Executive Team 26 June 2024	Sept 2025
Changes made yes/no:	Yes - 28 Sept 2023 Approved at Board Major revisions made	Yes - Intermediate updates; as approved at: 18/07/2024 Audit Committee and 25/07/2024 Health Board Meeting– Formalisation of the Risk Scrutiny Group, and key updates to the Risk Framework and Procedures.	Yes - Intermediate updates- Escalation route
	Yes	Intermediate updates - Updated Risk Appetite and updates to the RSG and EDG Reporting and escalation route	

PROPRIETARY INFORMATION

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CONTENTS

CONTENTS	3
GLOSSARY OF TERMS	4
RISK MANAGEMENT FRAMEWORK	6
1. PURPOSE OF THIS FRAMEWORK	7
2. SCOPE OF THE RISK MANAGEMENT FRAMEWORK	7
3. THE BOARD'S APPETITE FOR RISK	8
4. RISK MANAGEMENT PROCESS	8
Figure 1 - Risk Management Process	9
5. RISK ARCHITECTURE	10
Figure 2 - Risk Management Meeting & Escalation/De-escalation	13
Figure 3 - Risk Management Register	14
6. RISK STRATEGY	15
Figure 4 – Strategic Register Reporting Cycle	15
7. ROLES AND RESPONSIBILITIES	17
8. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT FRAMEWORK	25
Appendix 1	26
RISK APPETITE	26
EQUALITY IMPACT ASSESSMENT	27
REFERENCES	28

GLOSSARY OF TERMS

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. Risk is expressed in terms of likelihood (probability of the risk occurring) and consequence (impact if the risks were to occur).

Distinguishing between a risk and an issue: A risk is an event that might occur and that could have an effect (can be positive but usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty. An issue is something that has already happened or will definitely happen. An issue is a certainty. For example, 'we are short staffed' or 'lack funding to deliver a service', are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of funding to the successful delivery of our operational and strategic objectives. What these uncertainties (doubt) may cause, is what will constitute (give rise) to risks in both cases.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives.

Actions: Actions are the subsequent steps required following the application of controls to address or further mitigate residual (current) risk to as low as reasonably possible (target) level.

Board Assurance Framework: comprises of strategic risks developed by Board members from the Strategic Plans and Objectives that could prevent the Health Board's from fulfilling its strategic objectives/priorities.

Business Continuity: Business continuity is the capability of the Health Board to continue the delivery of products and services within acceptable timeframes at predefined capacity during a disruption. Business continuity is a temporary and alternative measure initiated during a disruption that ensures continuity of service provision whilst a permanent solution is found, or usual services/operations are resumed. The holistic process of business continuity management is an essential tool in ensuring an organisation's resilience.

Controls: These are measures or interventions implemented by the Health Board that reduce the likelihood of a risk and/or the impact/severity of a risk. The types of controls used in reducing risks include preventive, corrective, detective and directive controls. Gaps in control describe the weaknesses identified having put mitigation controls in place.

Corporate Risk Register: A corporate risk register is a repository used to record significant risks that could impact the strategic objectives and operations of the Health Board. Developed by services, corporate functions and members of the Executive Committee, the register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

Risk Assessment: This is the overall process of risk identification, analysis and risk evaluation. This is achieved by identifying risks, examining the characteristics of each risk and comparing individual risks against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, workshops and brain storming sessions, and inspections and audits.

Risk Appetite: The amount and type of risk that an organisation is willing to seek or retain in its pursuit of its objectives.

Risk Domain

A risk domain is a broad category or area of activity in which an organisation may face risk. It provides a way of grouping similar types of risks so that the organisation can consider, monitor and manage them consistently. Risk domains allow an organisation to recognise that it may have a different appetite for different kinds of risk

Risk Framework: Set of activities that support the risk management process, i.e., the risk architecture, strategy and protocols.

Risk Management: Coordinated activities to direct or control risks within an organisation. These are management activities that deliver the most favourable outcome and reduce the volatility and variability of that outcome.

Risk Mitigation: This refers to the process of reducing risk exposure through minimising its likelihood and/or lessening the severity of its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Senior Responsible Risk Officer (SRRO): This may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor.

Take Opportunity: The type of risk with potential to enhance the achievement of the organisation's objectives. Opportunity risk management is the approach that seeks to maximise on benefits of taking risks i.e., innovation, new systems, processes and procedures, services etc.

Terminate: Risk response that is appropriate when certain activities that give rise to risks are not necessary or worth doing and should be stopped. Also known as avoidance or elimination.

Tolerating: The decision to accept the risk and the impact should the following risk occur without taking any further steps to mitigate it. This is often to avoid significant investment or resources as the response would be disproportionate to the potential harm or gain. Also referred to acceptance or retention. Decision to tolerate any risks that are outside the risk appetite threshold for a particular domain of risk should be made at senior level proportionate to the level of risk.

Transfer: Risk response for risks outside the Health Board's appetite that the organisation wishes to transfer or share with other providers by way of contracts (outsourcing), insurance, joint venture etc. This option is particularly suited to mitigating financial risks or risks to assets.

Treat: Risk response by way of introducing cost effective controls to alter or reduce risk.

Target Risk: Ultimate level of risk that is desired by the Health Board when planned additional controls (see actions) have been implemented to address residual risk to as low as reasonably possible and/or within the Health Board's risk appetite.

RISK MANAGEMENT FRAMEWORK

- The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.
- The Health Board is committed to ensuring a robust infrastructure to manage risks ensuring an integrated approach, and where risks crystallise, to evidence improvement.
- The Health Board's intention is to **minimise** the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks, **maximise** performance and is **open** to opportunity with considered risk taking.
- To deliver **safe, quality** services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to **minimise** risk to the greatest extent possible and promote patient well-being as a duty of care to the population.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's appetite for risk (see Appendix 1-Risk Appetite Statement);
- Adopting an integrated approach to risk management in order to facilitate a cross-functional collaboration of system-wide risks that includes risks related to: clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and well managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;

- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses to ensure organisation wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and
- Providing appropriate training to staff to ensure effective implementation of risk management arrangement

1. PURPOSE OF THIS FRAMEWORK

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;
- that the wellbeing of patients, staff and visitors is optimised;
- that opportunities are maximised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

2. SCOPE OF THE RISK MANAGEMENT FRAMEWORK

This framework applies to Board members; all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

This framework will:

- Outline the risk management philosophy through our risk statement, identifying arrangements for embedding risk management;
- Explain the role, expectations and appetite of the Board in relation to risk and risk management;
- Detail the high-level roles and responsibilities for implementing and complying with this framework;
- Explain the arrangements for complying with all relevant legislation;
- Detail risk priorities for the present year;
- Detail the high-level Committee structure accountability in relation to risk, internal reporting requirements, assurance arrangements and external reporting controls;

- Signpost the specific policies, procedures and terms of reference and which the Health Board will publish to ensure that all staff understand what is required of them.

3. THE BOARD'S APPETITE FOR RISK

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk. The Board is prepared to accept some financial risk and regulatory challenges if appropriate controls and defence strategies are in place. The Board support innovation despite potential short-term quality impacts and reputational risks, as long as there is potential for long-term rewards like improved outcomes for stakeholders and opportunities for staff recruitment, retention and development. The Board takes a holistic view of value for money, with price not being the sole determining factor.

The Health Board seeks to be innovative and will challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated. The Board's annual Risk Appetite, detailing acceptable levels of risk across five risk types (Quality & Safety, Financial Sustainability & Stewardship, Regulatory & Compliance, Long Term Sustainability, Creativity & Innovation), is outlined in Appendix 1.

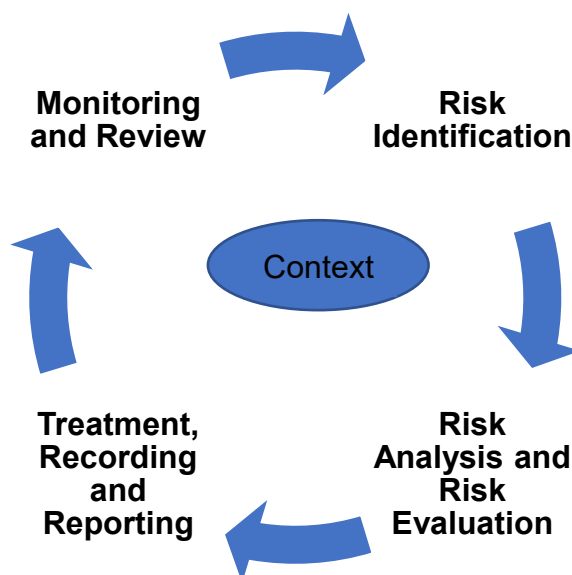
4. RISK MANAGEMENT PROCESS

Risk Management is the systematic application of management policies, practices and procedures to identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

Figure 1 - Risk Management Process



1. RISK IDENTIFICATION

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care. This should be done within context.

2. RISK ANALYSIS AND RISK EVALUATION

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. TREATMENT, RECORDING AND REPORTING

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a Datix risk register, which is a formal record of all risks raised, which makes up the Operational Risk Register.

4. MONITORING AND REVIEW

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

5. RISK ARCHITECTURE

The current enterprise risk architecture within the Health Board is shown below in a risk management model.

LEVELS OF RISK

The Risk Management Framework defines three levels of risk:

1. Strategic Risks – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.
2. Operational Risks – Risks that arise as a result of the day-to-day running of the Health Board and include a broad spectrum of risks comprising clinical risk (e.g., arising from incidents and complaints), financial risk (including fraud); legal risks (e.g., arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.
3. Project Risks – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

RISK REGISTERS

Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers can work together in an integrated risk management model:

Board Assurance Framework (BAF)

- Focuses on the top <10 strategic risks that could impact achievement of the Health Boards objectives and priorities.
- Owned by the Board and tied directly to the strategic plan.
- Risks reflect external and internal issues affecting strategy.
- Regularly reviewed by Committees, the Board, Executive Committee and Executive Delivery Groups.
- Held by the risk team.

Corporate Risk Register (CRR)

- Consolidates key risks escalated up from the operational level based on the possible impact on Boards objectives and priorities. May include 10-15 major corporate-wide risks.
- Provides Executive Delivery Groups and Executive Committee with enterprise view of significant operational and strategic risks.
- Enables corporate risk reporting, monitoring and oversight.
- Risk flows to BAF as appropriate.

Overseen by the corporate risk team,

Operational Risk Registers

- Day to day operational risks which impact on service delivery. Includes clinical, financial, compliance, IT risks etc.
- Mandatory for all services to have a register on Datix.
- Service Risk Leads or Risk Champions responsible for maintaining and managing service risk register and escalates higher risks through Senior Responsible Officers and Corporate Risk Team for awareness and where appropriate consideration on the CRR.

Project Risks

- Project lead responsible for ensuring risks are captured and maintained.
- Acceptable for the project risk register to be held locally (not on Datix) but significant risks which could impact on day to day operations or have a wider impact on the Health Board should be escalated to a Datix risk register to allow for overview and consistency of reporting.
- Project team escalate higher risks through Senior Responsible Officers and Risk Scrutiny Group for awareness.

This model provides top-down and bottom-up connectivity to enable robust risk management at all levels and alignment to strategy.

All staff should be aware of the potential for risks to emerge which may affect the business of the Health Board and all staff should be prepared to identify and report risks as appropriate. When a possible risk is identified, staff should aim to discuss it first with their line manager. This is to avoid duplication of effort, as sometimes risks are identified which are already being managed but have perhaps been articulated differently. Once it is confirmed that a new risk has been identified, the details should be entered onto the Datix system. This will normally be achieved through a service risk lead/champion.

Once correctly identified and assessed, the risk should be logged on a risk register, depending on the seriousness of the risk. Where possible risks should be managed at the lowest level possible, proportionate to the level of exposure to which the risk.

Risks scored ≥ 15 should be sent to the Senior Responsible Risk Officer (SRRO) (*N.B. this may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor*), for awareness and consideration on the CRR, if critical/strategic in nature. Operational risks scored ≥ 20 should be sent to the most senior responsible person for management support and advice.

Escalation decisions should also take account of the Board's risk appetite and tolerance levels. See Appendix 1

Risks scored 9>12, Risk owners are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all risks within their areas. They will be required to periodically present their Divisional risk register reports and assurance of robust risk arrangements to the Risk Scrutiny Group.

Risks scored 1-8 should be regularly reviewed, scrutinised, approved, reduced and managed at the service or departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant quality and safety meeting and/or the triumvirate.

ESCALATION/DE-ESCALATION

Risks should be regularly reviewed and escalated or de-escalated to the appropriate risk register within the Committee or divisional meeting which reviews the risk. Before a risk is presented to a SRRO for approval, it should be quality assured by the Corporate Risk Team and take the assurance that robust action plans are in place.

For escalation of a risk on to the CRR the service risk lead should contact their Executive Director through the appropriate channels and the corporate risk team via their regional risk manager.

Figure 2 - Risk Management Meeting & Escalation/De-escalation

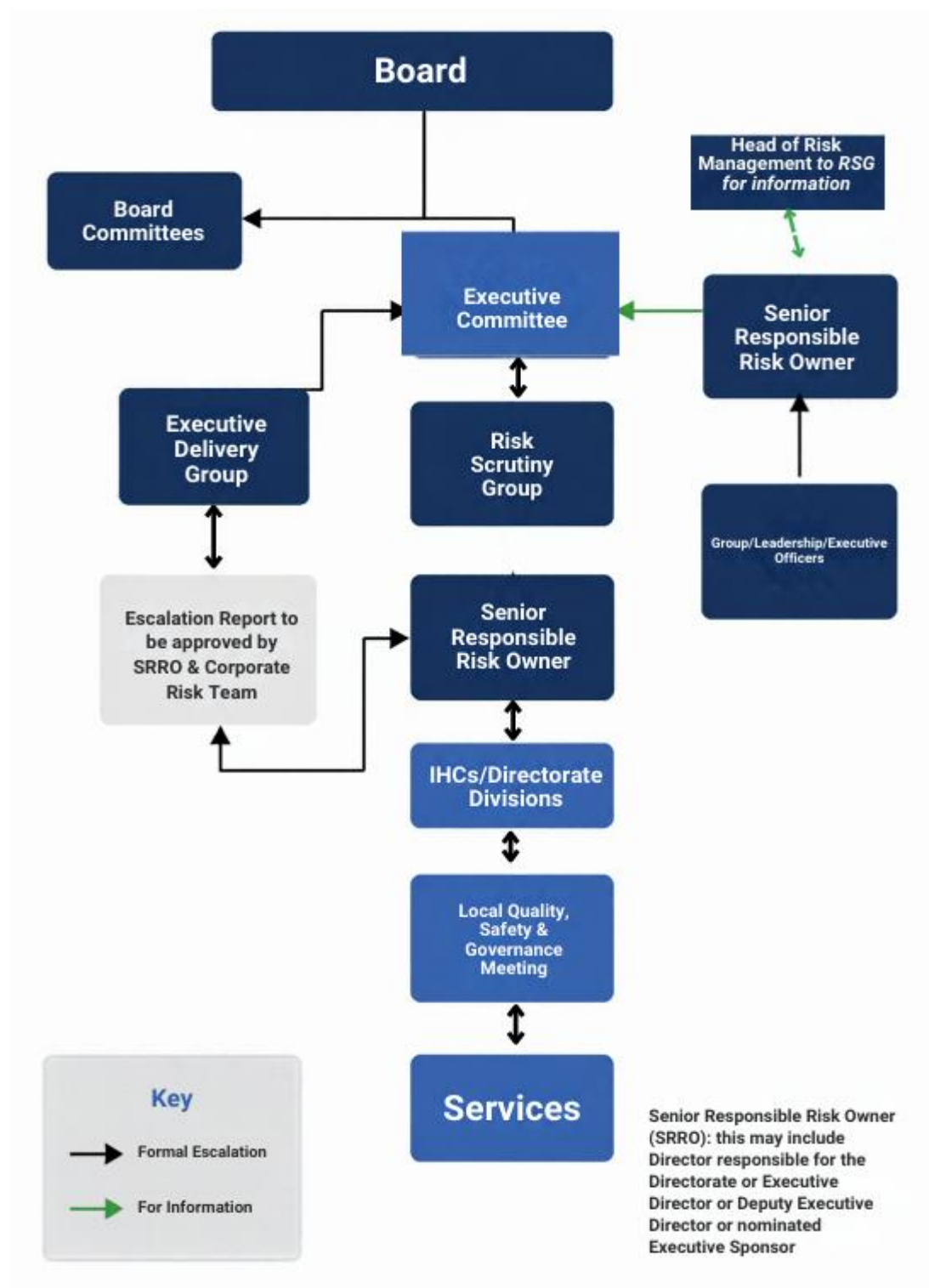
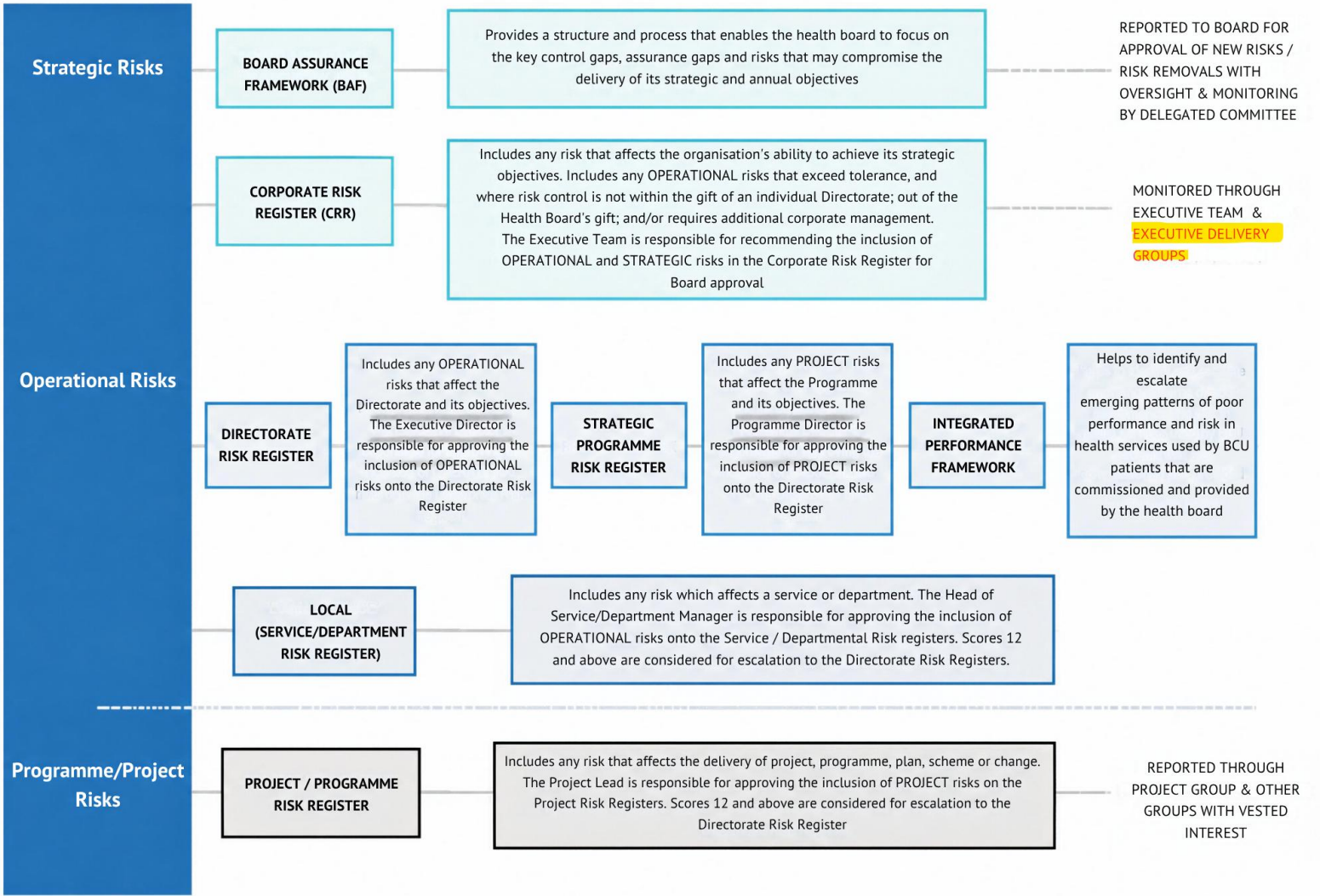


Figure 3 - Risk Management Register



6. RISK STRATEGY

To effectively manage risks, our organisation will take a comprehensive approach across several areas. This will include robust reporting mechanisms to keep leadership and the Board apprised of risks, using systems like risk registers to log and track risks, ensuring staff have adequate training and clear responsibilities, implementing standardised risk management processes, fostering a culture of openness around risks, and continuously monitoring and improving through quality assurance. Together these initiatives across reporting, systems, people, processes, culture and improvement will enable us to better anticipate, manage and mitigate the risks we face in alignment with our values and strategic objectives.

Reporting

- Services to provide their directorates on assurances over the management of the local service risk register.
- *Risk Scrutiny Group to oversee risk processes in line with procedures to supports continuous improvement and monitoring of trends in relation to KPIs (outlined in RM02).
- Corporate risk report to **Executive **Delivery Groups, Executive** Committee and Board Committees on risk actions plans and updates. Terms of reference and cycle of businesses for all support risk as a standing agenda item.
- Board Assurance Framework (BAF) risk report to Board.

Figure 4 – Strategic Register Reporting Cycle

Register /Tier	Review	Formal Review	Approval Escalation/ De-...	Committee Oversight	Board
Board Assurance Framework	Reviewed Bi-Monthly	Scrutinised through the relevant Executive Delivery Group	Executive Committee Meeting	Quarterly	Bi-Annually (or any escalations via Audit Committee Chair's report)
Corporate Risk Register				Quarterly	Quarterly

*The Risk Scrutiny Group provides assurance on operational risk management arrangements, risk maturity and organisational learning, **whilst Executive **Delivery Groups** provide scrutiny and assurance of corporate and strategic risks within their respective portfolio areas.

Systems

- Datix to be used to log risks.
- Risk priorities will influence integrated planning.

Processes

- Process in relation to risk management procedures are detailed in RM02 'Risk Management Procedures' and throughout this framework as well as RM03 outlines 'Risk Management Training Procedures' and plans. Risk identification, assessment and treatment processes as detailed in section 4.
- Risk monitoring and review processes, risk reporting and escalation processes.

Culture

- The cultural tone is detailed in the statement and approach to risk as well as supported by the way in which processes are carried out, dynamic and diligence. Risk clearly noted as everyone's business and supported by detailing responsibilities.

People

- Risk management responsibilities are clear for all staff and have been further detailed in section 7.
- The Health Board is committed to continuous learning which applies across risks management. Training as a part of ensuring continuous improvement is crucial. Knowledge of good identification processes and how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Level	Audience	Frequency
Level 1	All staff	Every 3 years
Level 2	Risk Handlers and Owners	Every 3 years
Level 3	Senior Leaders (*8b>)	Every 3 years
Level 4	Board	Every 3 years
Induction General Risk Awareness	All Staff	Upon commencement of employment

Strategic (BAF) Risks:

The 'three lines of assurance' have been outlined in relation to independent and objective audits and reviews of risk management practices 'The three lines of assurance' includes internal/external audit, regulators, professional body reviews and scrutiny. Provides assurance to senior management and Board on effectiveness of risk management.

The three lines of assurance also clarify roles for review and oversight:

First line of assurance: Reviews by operational management

Second line of assurance: Oversight by risk management/compliance functions

Third line of assurance: Independent assurance from audit/regulators

This model structures risk management oversight at the Risk Scrutiny Group Executive Committee, Board Committees and Board levels for the Health Board.

7. ROLES AND RESPONSIBILITIES

Effective risk management requires clear definition of the roles, responsibilities, and accountabilities across the organisation. This section outlines the duties and obligations relating to risk for the Board, relevant Committees, key groups and individuals within the Health Board.

THE BOARD:

The Board (Executives, Directors and Independent Members) being the governing body responsible for strategy, performance, governance, risk management, and ensuring statutory duties are met. The Board is accountable for effective oversight per NHS (Wales) Act and other healthcare regulations.

The cycle of business for the Board is set to receive the CRR and BAF on a quarterly/bi-annual basis. It is the duty of the Board to discuss and advise on the content and progress of action plans in the BAF. It is also the duty of the Board to appropriately monitor BCUHB's significant risks noted in the CRR, associated controls and assurances outline as well taking a view on the overall decision of tolerating a risk or challenging the possible lack of progression.

The Board is responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people are in place to manage risks and its effectiveness. The Board will be focused on key risks and driving the delivery of the Health Board's strategic objectives. Gaining assurance demonstrates good oversight of effective risk identification and management; risk architecture as well as due diligence including robust governance. It is a key principle of accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk. In the context of this Framework the Board will:

1. demonstrate its continuing commitment to risk management through the application and interest in the overall compliance with this Framework;
2. ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
3. take a proactive role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
4. commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
5. ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data;
6. oversee and participate in the risk assurance process;
7. allocate strategic risks to Committees for oversight;
8. ensure communication with partner organisations on problems of mutual concern including risks;
9. ensure that appropriate structures are in place to implement effective risk management; and
10. receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC):

Provides assurance on governance, risk management, internal controls, financial reporting and internal/external audits. The Committee is responsible for points 1-5 as noted above.

The cycle of business for the Committee is set to receive the CRR and BAF in its entirety on a bi-monthly basis. The Audit Committee, on behalf of the Board, will be responsible for providing oversight of the adequacy and management of the CRR and BAF arrangements.

PERFORMANCE AND FINANCE COMMITTEE (PFC):

Oversees financial and operational performance, and delivery of plans/targets. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

QUALITY SAFETY AND EXPERIENCE COMMITTEE (QSE):

Reviews quality of care, patient safety issues, clinical effectiveness and outcomes, patient experience. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

RISK SCRUTINY GROUP:

The Risk Scrutiny Group reports to the Executive Committee and advises on any risk management issues, including all significant risks arising from activities within the organisation.

The Group is responsible for providing oversight and assurance regarding the effectiveness of operational risk management arrangements across the organisation, ensuring appropriate escalation of significant operational risks. The Group will review organisational risk maturity, risk management performance, thematic risk issues and sources of assurance to support effective risk governance and organisational learning.

Specifically, the Group is responsible for:

- Operationalising the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating the escalation of all clinical and non-clinical risks, making recommendations to, and advising the Executive Committee and Board accordingly;
- Advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place
- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Reviewing significant themes, findings and recommendations arising from Internal Audit, inspections and other assurance activities, seeking assurance that appropriate actions are implemented and monitored.
- Monitoring organisational risk maturity and the embedding of risk management practices across the organisation.
- Reviewing risk management Key Performance Indicators (KPIs), metrics and trends to identify areas requiring improvement.
- Undertaking thematic reviews and deep dives into key operational risk areas to assess the effectiveness of controls and assurance arrangements.
- Reviewing emerging risks, cross-cutting risk themes and organisational learning from incidents, complaints, claims, audits and inspections.
- Providing assurance and advice to the Executive Committee regarding operational risk management arrangements and risk governance.

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EXECUTIVE COMMITTEE

The Executive Committee holds accountability for individual risks listed on the BAF and CRR and plays a key role in the ongoing review of the risk register. They are responsible for identifying risks that require escalation or de-escalation, and for providing regular updates on the progress of action plans aimed at mitigating and managing the risks under their remit.

7.1 INDIVIDUAL RESPONSIBILITIES

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework. The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

CHIEF EXECUTIVE (CEO)

The Chief Executive Officer (CEO) serves as the Accountable Officer for the Health Board, holding overarching responsibility for ensuring compliance with statutory and legal obligations, as well as adherence to governance guidance issued by the Welsh Government. This accountability extends across key areas including risk management, health and safety, financial and organisational controls, and overall governance. The CEO is ultimately responsible for

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974. The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

EXECUTIVES & DIRECTORS

Executives and/or Directors have overall responsibility for the operational management of risks within their Directorates and are the named senior responsible officer for individual risks on the CRR and BAF.

They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of risks

where appropriate. They shall also be responsible for ensuring that senior managers under their portfolio have effective risk management systems and processes in place in their directorates, divisions, sites, and services to demonstrate robust identification, assessment, mitigation and management of all risks.

They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio. Executives and Directors will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives and Directors play a pivotal role in setting the expected cultural tone, one which is positive and encourages identification, risk is not to be considered as negative or to be avoided. The Executives and Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives and Directors will seek assurances that risk training is well attended for their regions and departments. Good risk awareness, awareness of roles and responsibilities, timely management of action plans, and a sense of accountability. Executives and Directors will seek assurances respective risk registers are maintained regularly, action plans are well managed, well communicated and actions which have blocks are escalated in a timely manner. Registers are expected to be agile and reflective of the service. Executives and Directors will foster a culture of continuous improvement supporting teams to engage with Better by Betsi, a community of continuous improvement, enhancing innovation with risk identification, mitigations strategies for their service. Executives will take a proactive identification approach to counter fraud risks.

In addition, Clinical Executive Directors (Executive Medical Director, Executive Director of Nursing & Midwifery, Executive Director of Therapies & Health Sciences, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

DIRECTOR OF CORPORATE GOVERNANCE

The Director of Corporate Governance is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated BAF and Risk Management Framework.

The Director of Corporate Governance will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;

- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- lead the ongoing development of the Risk Scrutiny Group (established by the Executive Committee).

HEAD OF RISK MANAGEMENT

The Head of Risk Management is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the BAF;
- support the management and development of the BAF and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the CRR and BAF, for Board;
- support the development and functioning of the Risk Scrutiny Group; and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the BAF.

CORPORATE RISK TEAM

The corporate risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation. The team will support the escalation of risks the CRR and BAF. The risk management team will support services by validating risk registers, including the adequacy of the risk descriptions, controls, and assurances and justification of the risk scoring and take a lead on assurances of compliance pan BCU.

They will advise all colleagues including Executives and Directors in managing their risks. The risk team will lead the development of procedures as required under this framework. They will ensure the delivery of training to staff who have responsibilities under this policy. They will be responsible for the overall management of the risk module in Datix.

SENIOR MANAGERS

Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership.

They are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. The risk service lead and risk team will work with senior managers to ensure risks are articulated appropriately and described in line with procedures and will further support organisational wide learning.

The risk management team will provide healthy challenge and support to those risks that do not have adequate actions or action plans and have not progressed in a timely manner with a route to escalation to **SRROs**. Senior manager will provide SIROs with regular assurances around effective management of risk registers.

SERVICE RISK LEADS

Services are required to nominate a risk lead/champion on behalf of the service to ensure the risk register is well maintained and risk is championed throughout the service facilitating good identification processes. Service risk leads will support the operational management of their respective service risk register and will liaise with the risk management team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

ALL STAFF

All staff including, Trade Union colleagues and contractors are required to comply with this Risk Management Framework, raise any issues of concern to the attention of their line manager and to appropriately minimise and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board. Risk is the responsibility of all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business.

INDEPENDENT MEMBERS (IMs)

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust, positive and effective challenge to the Executives, Directors and senior management. IMs are expected to satisfy themselves that the Health Board's risk management arrangements are effective, efficient and fit-for-purpose. IMs will provide healthy challenge on those risks that are not treated in a timely manner; the overall decision to tolerate the risk and/or the risks alliance to Health Board objectives.

IMs will challenge overall Board decision-making ensuring this is within the Boards risk appetite. In addition, IMs chair Board Committees and in line with the relevant Committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board. IMs should seek assurance in ensuring a measured risk culture.

INTERNAL AUDIT

The relationship between risk management and Internal Audit is critical. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

- a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;
- b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;
- c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;
- d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

LOCAL COUNTER FRAUD SERVICES

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the Audit Committee identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit Committee as appropriate. The LCFS works with the Chief Executive, Executive Committee and Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the Health Board's escalation process. The Executive Committee recognises that fraud, bribery, and corruption pose significant risks that require proactive management. To protect the interests of our stakeholders, act ethically, and comply with counter fraud laws and regulations, we commit to proactively identify fraud risks and vulnerabilities across the Health Boards operations through audits, reviews of complaints and allegations, and risk assessments. Routinely assess changes that may impact exposure to fraud, bribery and corruption. This also includes effective controls tailored to the highest risk areas identified. This includes clear financial

controls, investigation and response diligence, training, and ensuring robust channels for reporting concerns.

SENIOR INFORMATION RISK OFFICER

The Board will nominate an Executive or Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

8. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT FRAMEWORK

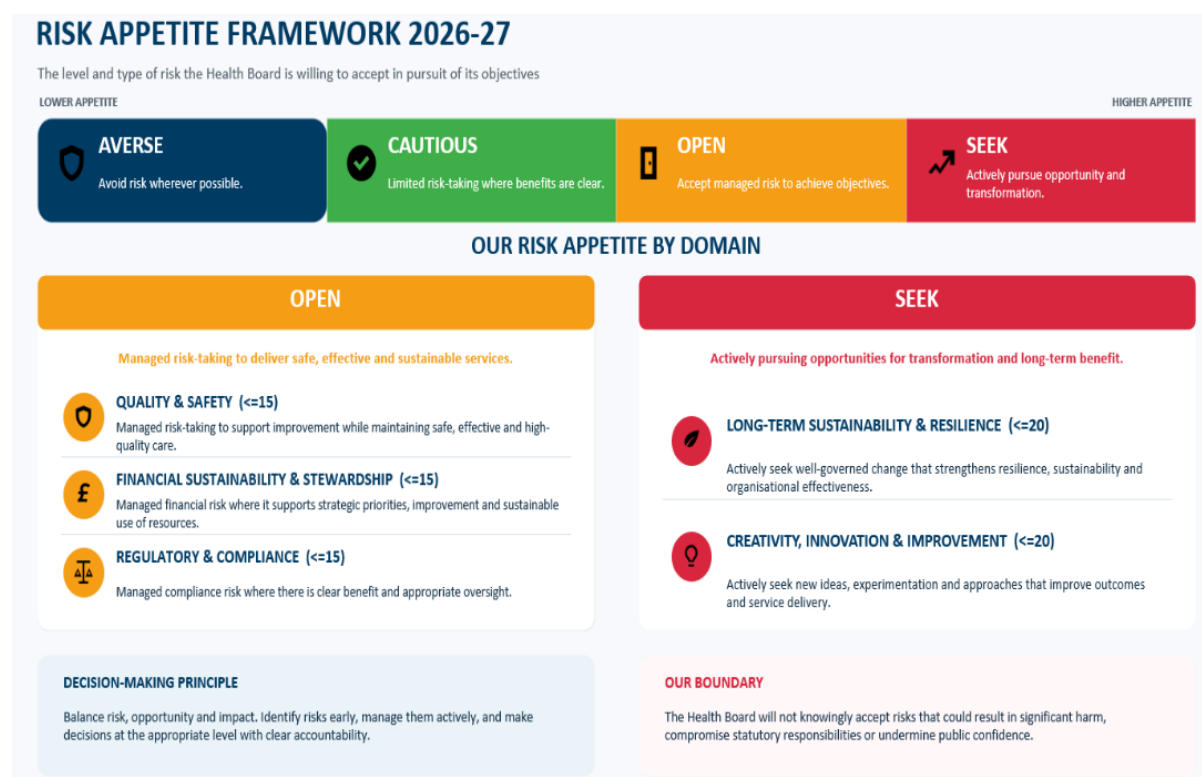
Compliance with this Framework is monitored by the Executive Committee and the Audit Committee. The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report. The Corporate Risk Team and Risk Scrutiny Group will take a lead on seeking assurances and providing Committees and Board with an overview of the Health Board's effectiveness and compliance. The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year.

The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process. The risk management framework draws from best practice standards ISO31000, policy, and legislative instruction such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The Health Board understands that risk is inherent in every business and is committed to ensuring full compliance.

This document should be read in conjunction with the 'Risk Management Procedures' (RM02) and 'Risk Training Procedures' (RM03) which are supportive of this Framework and outline all the procedural requirements for managing a risk operationally through to escalation.

Appendix 1

RISK APPETITE



1. Quality & Safety	Appetite: OPEN (≤15)
<p>The Health Board is committed to delivering safe, effective and high-quality care. We recognise that service improvement and transformation involve some degree of risk and are prepared to accept managed risks where there is a clear benefit to patients, services or outcomes.</p> <p>Quality and safety risks will be identified, monitored and managed through appropriate controls and assurance arrangements. We will not knowingly accept unmanaged risks or avoidable harm arising from poor decision-making or inadequate controls.</p>	
2. Financial Sustainability & Stewardship	Appetite: OPEN (≤15)
<p>The Health Board has a statutory responsibility to achieve financial balance and ensure good stewardship of public resources. We are prepared to accept managed financial risks where they support strategic objectives, service improvement, innovation or long-term sustainability.</p> <p>Financial risks will be actively managed and balanced against quality, workforce and performance considerations. We will not knowingly accept unmanaged financial risks that threaten service delivery, financial resilience or statutory responsibilities.</p>	
3. Regulatory & Compliance	Appetite: OPEN (≤15)
<p>The Health Board recognises that some regulatory and compliance risk is unavoidable when delivering complex healthcare services and transformational change. We are prepared to accept managed risks where there is a clear organisational, service or patient benefit.</p>	

We will seek to comply with all legal, statutory, regulatory and professional requirements and proactively manage areas of non-compliance. We will not knowingly accept risks that could result in significant harm, regulatory sanctions, governance failure or loss of public confidence.

4. Long Term Sustainability

Appetite: SEEK (≤20)

The Health Board actively seeks opportunities to strengthen long-term sustainability, resilience and organisational effectiveness. We recognise that achieving sustainable services requires transformation, innovation and a willingness to challenge established ways of working.

We are prepared to accept higher levels of managed risk where this supports long-term sustainability and improved outcomes for patients, staff and communities. We will not knowingly accept risks that could result in significant harm, compromise statutory responsibilities or undermine safe and effective service delivery.

5. Creativity & Innovation

Appetite: SEEK (≤20)

The Health Board actively seeks opportunities for creativity, innovation and continuous improvement. We recognise that improving outcomes and transforming services requires new ideas, experimentation and responsible risk-taking.

We are prepared to accept higher levels of managed risk where there is clear potential to improve services, outcomes or organisational effectiveness. We will not knowingly accept risks that could result in significant harm, compromise statutory responsibilities or undermine public confidence.

Score tolerances (inline with risk appetite) against each risk type should be managed throughout the Health Board in line with domain scores.

Risk score tolerances, in line with the Health Board's Risk Appetite Framework, are set for each risk domain. Risks should be managed in accordance with the agreed tolerance for the relevant domain.

EQUALITY IMPACT ASSESSMENT

The Health Board has undertaken an Equality Impact Assessment on the implementation of the Risk Management Framework and procedures to ensure that it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Any RAG ratings in Datix and other documents will have descriptors for those with colour blindness and RM01-03 will be available in Welsh as well as all risk training. Further support to understand the document is also available through bespoke support and training through the corporate risk team. Any other challenges to implement or apply these Risk Management documents can be communicated to the corporate risk team in order to ensure the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

REFERENCES

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Good Governance Institute (2018) Risk Appetite Matrix https://www.good-governance.org.uk/wp-content/uploads/2020/05/GGI_RiskAppetite_CHV19-version3.pdf

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NHS Leadership Academy (2013) The Healthy NHS Board 2013 – Principles for Good Governance. Available at: www.leadershipacademy.nhs.uk

Public Interest Disclosure Act 1998. (c.23). London: The Stationery Office.

WHC (2000)13 – Corporate Governance in the NHS in Wales: risk management and organisational controls.

Included a desktop review of Welsh Health Boards Risk Frameworks

Audit , Risk and Assurance Committee

Post Payment Verification (PPV) Mid-Year Report April 2026 – Sept 2026

Date of Meeting	20 October 2026
Publication Status	Closed / Private
	Commercially Sensitive
Report Author(s) name and title	Amanda Legge, All Wales Post Payment Verification Manager
Lead Executive Team Member name and title	Alan Weeks – Interim Executive Director of Finance

Report Purpose	For Approval
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Executive Summary

The Audit, Risk & Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

There are no options included in this report. The report is for assurance and will only detail specific risks, if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
Joanna Garrigan Finance Director Planning & Commissioning	6.10.26	Approved for submission

Acronyms / Glossary of Terms



PPV	Post Payment Verification
GMS	General Medical Services

SITUATION

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

BACKGROUND

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress.

The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

SPECIFIC MATTERS FOR CONSIDERATION

The following key points should be noted:

General Medical Services (GMS)

Progress against the 2026/27 GMS visit programme is progressing well. During the first quarter, all PPV teams focused on undertaking routine GMS revisits alongside routine visits where required. As the backlog of work has now been addressed, the team is undertaking practice revisits arising from previous findings, routine visits that have become due, and any ad hoc requests received from Health Boards.

A proportion of vaccination claims are now processed through the Welsh Immunisation System (WIS). Following issues identified by PPV during verification activities, new internal control processes have been implemented to prevent duplicate vaccination payments prior to payment being made, rather than relying on post-payment recovery processes.

General Ophthalmic Services (GOS)

The GOS visit programme for 2026/27 is progressing more effectively than in recent years. This improvement is primarily due to the increased number of contractors who have adopted electronic patient records, enabling PPV to undertake a greater proportion of verification activities remotely.

However, elements of physical visits remain necessary, as not all contractors currently operate electronic record systems.

General Pharmacy Services (GPS)

During 2026/27, the PPV team continues to undertake verification of the Collaborative Working Scheme and the Quality and Safety Scheme. These reviews are conducted remotely, with data held by PPV being verified against supporting evidence requested from contractors.

In addition, PPV successfully conducted a pilot review of the Winter Incentive Scheme for one Health Board. The pilot produced positive outcomes, and the approach is now being rolled out nationally. The results will be incorporated into the year-end report.

Additional Services

Quarterly dispensing data checks continue to be undertaken, with ongoing enhancements being made to strengthen and streamline the process, ensuring a robust service moving forward. Results relating to the 32 dispensing practices within Betsi Cadwaladr University Health Board have been incorporated into PPV reporting.

Waste Management and Stakeholder Engagement

The PPV team continues to manage the Waste Management Audit Programme on behalf of Health Boards, providing advice and support to General Practitioners and Community Pharmacies regarding waste management requirements. This includes overseeing the clinical waste self-assessment process, which contractors are required to complete every three years.

During this financial year, GOS contractors will also be incorporated into the clinical waste assurance process.

Regular meetings are held with Health Board Primary Care Teams and Counter Fraud Teams to review progress, discuss emerging themes, recommendations and identified risks. In addition, the team facilitates quarterly national GMS and GOS Working Group meetings with Primary Care Managers and PPV representatives to support discussion and agreement on matters relating to the consistent national application of the programme. These meetings continue to provide valuable opportunities for collaboration and shared learning.

Training and Development

PPV training continues to be delivered to Health Boards and contractors as required. The team also provides tailored one-to-one support where requested, particularly for new practice staff working within primary care settings.

Data and Reporting

PPV data analysts are currently developing a suite of dashboards to enhance management information and reporting. These dashboards will provide additional insight and are intended to support future committee reporting requirements.

RECOMMENDATIONS

The Committee/Meeting/Group is asked to:

- **NOTE** the contents of the PPV Annual Report 2025/26
- **TAKE ASSURANCE** from the contents of the report

ASSESSMENT	
Link to Strategic Priorities	    
	1. Building an effective organisation
Design Principles	Consistency with Organisational Values
Corporate Risks and Board Assurance Framework	<i>Risk to Financial balance</i>
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable



IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)."
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: x
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	Not applicable to a report of this nature.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable to a report of this nature.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable to a report of this nature.
Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality Choose an item.	Domains of Quality Choose an item.
	If more than one applies, please list below:	If more than one applies, please list below:
	<i>Please list other Enablers of Quality in here</i>	<i>Please list other Domains of Quality in here</i>
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
	<i>If more than one applies, please list below:</i>	
Environmental /Sustainability Impact (5Rs)	Yes - Refine	
	If more than one applies, please list:	
	If no, please include rationale:	
Data Protection Impact Assessment	Yes: ☐	No: ☒
	Outcome:	

<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	If no, please include rationale:	<i>This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).</i>
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Counter Fraud presence in ARAC meetings
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	Yes (Include further detail below)	
	Financial	
Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	Better use of NHS resources	

Audit Report - April to September 2026 - Betsi Cadwaladr University Health Board

General Medical Services (GMS)	Betsi Cadwaladr							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2025 - 2026	Combined		47				£78,582.00		156			£228,801.68
GMS 2026-2027	Routine	27	9	341	£8,111.71	£2,521.17	£10,632.88	95	63	£15,071.29	£15,939.72	£31,011.01
	Revisit	54	9	3728	£30,548.60	£683.20	£31,231.80	169	65	£74,722.65	£683.20	£75,405.85
	TOTAL	81	18	4069	£38,660.31	£3,204.37	£41,864.68	264	128	£89,793.94	£16,622.92	£106,416.86

General Ophthalmic Services (GOS)	Betsi Cadwaladr					ALL WALES		
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
GOS 2025-2026	Combined		30		£5,016.17		138	£20,003.35
GOS 2026-2027	Routine	31	21	55	£1,843.53	145	63	£3,188.45
	Revisit	22	2	0	£0.00	64	14	£1,732.86
	TOTAL	53	23	55	£1,843.53	209	77	£4,921.31

General Pharmacy Services (GPS)	Betsi Cadwaladr					ALL WALES			
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
GPS 2025 - 2026	Combined		47		£9,701.80		232		£44,803.70
GPS 2026 - 2027	Routine	56	0		£0.00	281	0		£0.00
Due to commence in Quarter 3 of 2026/27	TOTAL	56							

New Recovery process					
	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
DISPENSING 2025-2026	Quarter 1 & 2 2025/26 (Apr to Sep 2025)	32	£29,475.93	64	£42,478.77
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy					

GMS Summary									
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate	
Practice 1	Revisit	16764	530	3.16%	£3,363.91	£0.00	£3,363.91	Immunisations and DOAC/R	
Practice 2	Routine	435	59	13.56%	£1,387.43	£1,029.72	£2,417.15	Care Homes, Contraceptives, Immunisations, MGUS, NPT, DOAC/R, Gonadorelin. Duplicate recoveries on Diabetes, Covid, Gonadorelins, Flu, Contraceptives, RSV and Warfarin B.	
Practice 3	Revisit	1121	68	5.98%	£894.40	£683.20	£1,577.60	Care Homes	
Practice 4	Routine	16107	107	0.66%	£2,407.50	£0.00	£2,407.50	Asylum Seekers, Contraceptives, Immunisations, Minor Surgery, NPT, Warfarin A, Ukranian Refugees, Wound Care. Duplicate recoveries on Covid, Gonadorelin, Transgender, Flu, Contraceptives, DOAC/R and Warfarin A.	
Practice 5	Revisit	7193	1141	15.86%	£5,503.94	£0.00	£5,503.94	Immunisations and DOAC/R	
Practice 6	Routine	297	117	39.39%	£3,455.67	£1,188.79	£4,644.46	Asylum Seekers, Care Homes, Contraceptives, Homeless, Immunisations, MGUS, Minor Surgery, NPT, DOAC/R, Warfarin, Ukranian Refugees, Gonadorelin. Duplicate recoveries on Gonadorelin, Homeless, Contraceptives, MGUS, NPT, Flu and Warfarin.	
Practice 7	Revisit						£0.00	In progress	
Practice 8	Routine						£0.00	In progress	
Practice 9	Revisit	4291	31	0.72%	£364.35	£0.00	£364.35	Flu, Learning Disabilities and Gonadorelin	
Practice 10	Routine	405	27	6.67%	£315.29	£64.92	£380.21	Care Homes, Contraceptives, Homeless, Immunisations, MGUS, NPT, DOAC/R, Warfarin, Transgender, Wound Care. Duplicate recoveries on Diabetes, DOAC/R, Immunisations and Transgender.	
Practice 11	Revisit						£0.00	In progress	
Practice 12	Routine						£0.00	In progress	
Practice 13	Revisit	2392	846	35.37%	£16,608.79	£0.00	£16,608.79	Asylum Seekers, Contraceptives, Immunisations, Non-Minor Surgery, DOAC/R, Gonadorelin. Duplicate recoveries on Care Homes and Flu.	
Practice 14	Routine	145	27	18.62%	£467.05	£167.53	£634.58	DOAC/R and Wound Care.	
Practice 15	Revisit	1215	1112	91.52%	£3,813.21	£0.00	£3,813.21	Contraceptives, NPT and Gonadorelin. Duplicate recoveries on Immunisations.	
Practice 16	Routine	180	4	2.22%	£78.77	£70.21	£148.98	In progress	
Practice 17	Revisit						£0.00	In progress	
Practice 18	Routine						£0.00	In progress	

Advisory Notes

- The planned visits were sent to the HB for 2026/27 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers.
- All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed.
- The duplicate amount of recovery is due to the practice submitting certain additional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors.
- The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns.
- PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise.
- Training/support is given to practices by PPV after their visit when requested.
- Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims.
- Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole.
- Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.

GOS Summary									
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery		Breakdown of Recoveries and individual services with 10% or more error rate		Advisory Notes
Practice 1	Routine	103	4	3.88%	£165.76		GOS 4 claims		<ul style="list-style-type: none"> • The planned visits were sent to the HB for 2026/27 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers. • As contractors are transitioning to electronic records, remote access and physical visits are progressing well
Practice 2	Revisit						In progress		
Practice 3	Routine	103	3	2.91%	£135.06		Claim recovery under 10% per service		
Practice 4	Routine	103	7	6.80%	£96.24		GOS 4 claims		
Practice 5	Routine	103	0	0.00%	£0.00		All claims verified		
Practice 6	Routine	103	1	0.97%	£22.37		Claim recovery under 10% per service		
Practice 7	Routine	103	1	0.97%	£10.17		Claim recovery under 10% per service		
Practice 8	Routine	71	0	0.00%	£0.00		All claims verified		
Practice 9	Routine	103	2	1.94%	£375.20		Claim recovery under 10% per service		
Practice 10	Routine	103	3	2.91%	£98.07		Claim recovery under 10% per service		
Practice 11	Routine	103	3	2.91%	£83.22		Claim recovery under 10% per service		
Practice 12	Routine	103	0	0.00%	£0.00		All claims verified		
Practice 13	Revisit						In progress		
Practice 14	Routine	103	0	0.00%	£0.00		All claims verified		
Practice 15	Routine						In progress		
Practice 16	Routine	103	5	4.85%	£178.48		Claim recovery under 10% per service		
Practice 17	Routine						In progress		
Practice 18	Routine	103	10	9.71%	£348.42		Claim recovery under 10% per service		
Practice 19	Routine	103	0	0.00%	£0.00		All claims verified		
Practice 20	Routine	103	1	0.97%	£10.17		Claim recovery under 10% per service		
Practice 21	Routine	103	1	0.97%	£54.23		Claim recovery under 10% per service		
Practice 22	Routine	103	13	12.62%	£240.14		GOS 4 claims		
Practice 23	Routine	103	1	0.97%	£26.00		Claim recovery under 10% per service		

Audit, Risk and Assurance Committee

NWSSP PROCUREMENT SERVICES ANNUAL ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	NWSSP Procurement Services Annual Assurance Report
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Assurance
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Crynodeb Gweithredol Executive Summary

The 2025/26 NWSSP Procurement Services Annual Assurance Report provides the Audit Committee with assurance on procurement activity undertaken on behalf of BCUHB and identifies areas where stronger management action and oversight are required. The report confirms delivery of £2.015m cash-releasing savings against the £2m target. It also records 158 contracts above £25,000 with a total value of £95.56m, 236 quotations valued at £2.88m and 65 waiver requests, of which 58 were approved and seven rejected.

However, the assurance is qualified by continuing control weaknesses. These include 87 Audit Committee Reportable Breaches relating to retrospective expenditure, valued at £5.479m; retrospective purchase orders averaging around 1,000 per quarter; more than 600 No PO No Payment invoices in each quarter; requisition turnaround remaining below the 90% All Wales target; the increased value of direct awards; and outstanding actions to progress Scan for Safety and product-to-patient traceability.

These findings align primarily to CRR25-06, Value Delivery and Financial Sustainability, which remains above appetite with a current score of 20 against a financial risk appetite threshold below 15. They also provide supporting assurance

for CRR25-08, Non-Compliance with Regulatory and Legislative Requirements, which has a current score of 12 and is within tolerance.

The Committee is therefore asked to consider the adequacy of the assurance provided.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	7 th October 2026	Approved

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

PROCUREMENT SERVICES ANNUAL ASSURANCE REPORT

1. Y SEFYLLFA SITUATION

- 1.1 The attached report provides an overview and specific details relating to Procurement activity undertaken by NHS Wales Shared Services Partnership on behalf of BCUHB during the 25/26 Financial Year.

2 Y CEFNDIR BACKGROUND

- 2.1 Following the Internal Audit review of BCUHB's Contract Management & Procurement Procedures during the 23/24 Financial Year, Audit & Assurance Services recommended that NWSSP Procurement Services should provide BCUHB with an Annual Assurance Report every year with specific details relating to the management of procurement activity on behalf of the Health Board.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

The report confirms that the £2m full-year cash-releasing savings target was exceeded, with £2.015m delivered. It also reports 158 contracts above £25,000 with a total value of £95.56m, 236 quotations valued at £2.88m, and 65 waiver requests, of which 58 were approved and 7 rejected.

The Committee is asked to give particular consideration to: 87 Audit Committee Reportable Breaches relating to retrospective spend, valued at £5.479m; the continuing level of retrospective purchase orders, averaging around 1,000 per quarter; more than 600 No PO No Payment invoices in each quarter; requisition turnaround remaining below the 90% All Wales target despite improvement to 85.1% in Q4; the increased value of direct awards, noting that £36m related to outsourced surgical specialties; and the outstanding action to test and activate the Scan for Safety patient feed and establish Executive sponsorship for the associated Task and Finish Group.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

The report details a number of areas which are managed by NWSSP, including: Cash-Releasing Savings Position, Contracting Position (Quotations & Tenders), Single Tender Waivers & Retrospective Expenditure, details relating to Transactional Key Performance Indicators (KPIs) and Welsh Government Policies.

5 ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp: The Committee is asked to:

- **REVIEW** the report and consider the adequacy of the assurance provided;
and
- **NOTE** the specific areas requiring further management attention.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	<ul style="list-style-type: none"> CRR25-06, Value Delivery and Financial Sustainability, current score 20 against a financial appetite threshold below 15, so it remains above appetite. CRR25-08, Non-Compliance with Regulatory and Legislative Requirements, current score 12 and within tolerance.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No direct equality impacts have been identified. The paper reports assurance on existing procurement activity and does not propose a new policy, service change or strategic decision.
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	A separate equality assessment is not required for this assurance report. Any subsequent service or procurement decision arising from the report should complete the appropriate assessment at that stage.
	Do/Yes: ☒	Naddo/No: X
	Canlyniad/Outcome:	No direct socio-economic impact has been identified

<i>compliance of the Socio-economic Duty when making strategic decisions?</i>		because the paper does not seek approval for a strategic decision.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report provides retrospective assurance on procurement activity. Due regard should be considered within any future strategic procurement or service decision.
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	Not required for this assurance report, as no new policy or service change is proposed.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Any action arising that changes services, policy or access should be assessed separately.
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No specific human rights impact has been identified from the assurance report.
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No direct Welsh language impact has been identified. Any future procurement or service change should consider applicable Welsh language requirements.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	A separate Welsh language impact assessment is not required for this

		retrospective assurance report.
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No specific impact on the Armed Forces community has been identified.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report does not propose a policy or service change requiring a separate assessment.
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No direct quality or patient safety impact arises from receiving the report. Effective procurement controls, product traceability and progression of Scan for Safety support safe, reliable and value-based services.
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Quality enablers: governance, learning and improvement, and whole-system working. Outstanding Scan for Safety actions require continued oversight.
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Globally Responsible Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Yes - Reduce	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	No separate environmental assessment is required for the assurance report. Environmental impacts should be assessed within individual procurements where relevant.
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	The paper does not propose new processing of personal data or a change to an existing information-processing activity.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	A Data Protection Impact Assessment screening is therefore not required for this assurance report. Any new data processing arising from future actions should be screened separately.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Counter-fraud considerations are relevant to the control environment, including waivers, retrospective expenditure, purchase orders, direct awards and compliance with procurement requirements.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Continued management oversight and escalation of control breaches will support fraud prevention and financial governance.
Cyfreithiol Legal	Yes (Include further detail below)	
	The report supports oversight of compliance with procurement requirements and internal controls. Any	

	non-compliance, waiver or retrospective expenditure should continue to be managed, documented and escalated through the appropriate governance route.
Enw Da Reputational	Yes (Include further detail below) There is a reputational risk if procurement breaches, retrospective expenditure, direct awards or weak purchase-order compliance are not addressed. Transparent reporting, named ownership and monitored actions will help mitigate this risk.
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report. The report confirms delivery of £2.015m cash-releasing savings against the £2m target. Management capacity will be required to deliver and monitor the action plan, improve compliance and progress the outstanding Scan for Safety actions. No additional resource approval is requested through this paper.

PROCUREMENT SERVICES ANNUAL ASSURANCE REPORT BETSI CADWALADR UNIVERSITY HEALTH BOARD

FOREWORD

I am pleased to be able to take this opportunity to introduce the NWSSP Procurement Services Annual Assurance Report for BCUHB for 2025/26. The year has been both challenging and exciting for our teams across Wales as we continue to operate in a turbulent and often unpredictable geo-political global environment which has direct impacts on our international and domestic supply chains.

Closer to home, we are also working at a national, regional and local level to support NHS Wales organisations in the delivery of savings, procuring services to address the waiting list targets and continuing our work to increase NHS Wales expenditure within the local economy while being mindful of the opportunities to reduce the carbon footprint of “what we buy” and “how we buy it”. None of this would be possible without the positive, collaborative working relationships and high levels of engagement we continue to enjoy with all our stakeholders, including BCUHB, for which we are very grateful.

I wish to briefly give you a flavour of some of the key procurement issues and deliverables within the year, all of which will have had an impact on your Health Board.

Overhaul of Procurement Legislation

In February 2025, the underpinning legislation for public procurement across the UK, The Public Contracts Regulations 2015, was replaced with the Procurement Act 2023. This was the most significant change to public procurement legislation in decades as we finally moved from EU derived regulations to UK, domestic legislation. The new legislation includes increased flexibility for the design and execution of procurements through wider market engagement and tender design. There are also challenges including a greater level of transparency than before requiring more information to be provided and published supporting decisions to award contracts.

Alongside this change, an additional piece of legislation was introduced within Wales to govern the procurement of healthcare services. From February 2025, The Health Services (Provider Selection Regime) (Wales) Regulations 2025, provides greater flexibility for the NHS in Wales to contract with existing and new healthcare services providers however there is also a greater onus on NHS Wales organisations to fully record and justify their decisions and publish notices to improve transparency.

Procurement Services staff have undertaken full training on the new legislation and have in turn provided training and awareness sessions to key stakeholder groups, including BCU's Executive Team and the Health Board's Healthcare Commissioning Team.

Value & Sustainability

The savings outturn position for 2025/26 was reported to the National Value & Sustainability Board with the actual figure outstripping the target to deliver just over £58m of cash releasing savings on an All Wales basis. Plans are already in place to stretch the target position for 2026/27 and progress will continue to be monitored throughout the year.

Strategic Projects

Procurement Services continues to be commissioned to deliver strategic programmes of work on behalf of NHS Wales organisations and Welsh Government. Many of the projects shown below commenced in 2025/26 with delivery expected within 2026/27. National programmes such as the procurement of Digital Maternity Cymru have been successful to date in providing a single national provider with a single national price and common operating requirements. Teams have worked hard to pick up and deliver this piece of additional activity at short notice. Also of note is the All Wales Influenza Vaccination Programme which continues to build towards the autumn 2026 season supported by a single national procurement of vaccine with associated savings and planned dispensing and distribution of vaccine to several hundred primary and secondary care locations across Wales.



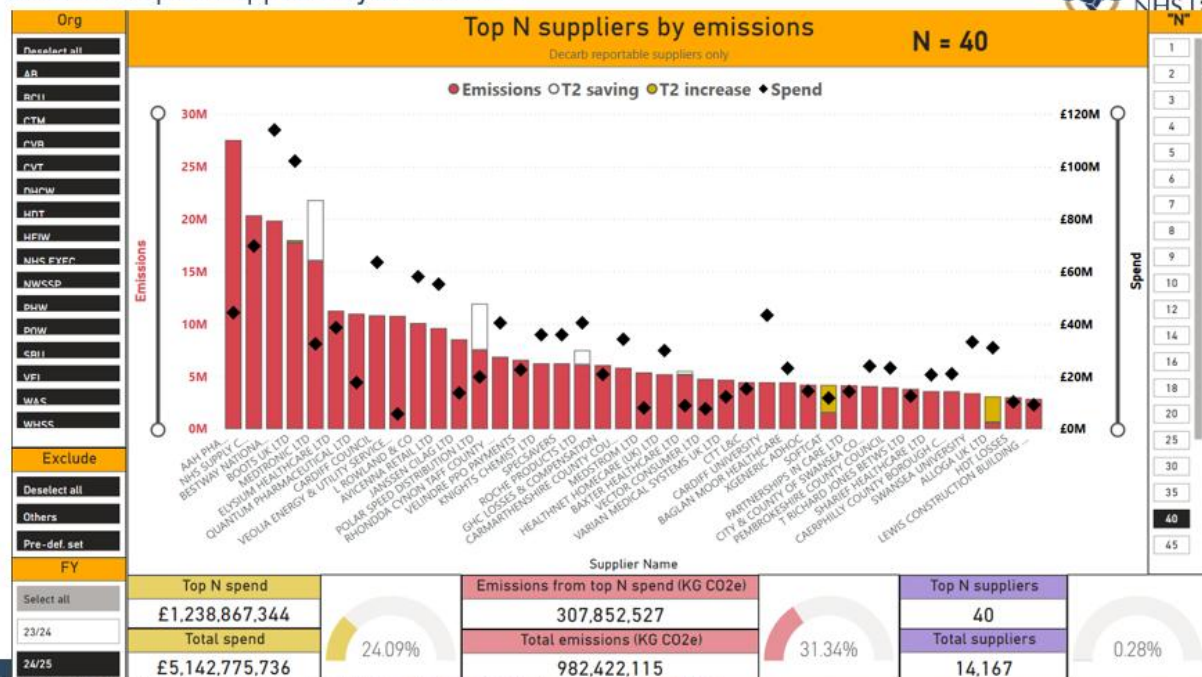
Foundational Economy

The level of NHS Wales spend with Welsh based suppliers during 2025/26 was maintained at previous levels of approximately 45% of total NHS Wales expenditure which equates to approximately £1.5 bn. Targets for the forthcoming year, 2026/27 have been set to increase this level of expenditure by a further 2 % with a focus on national procurement activity providing a greater level of opportunity to local and regional suppliers of goods and services where the supply base exists.

Decarbonisation

Procurement Services continues to play a critical role in the National Transport and Procurement Project Board which supports delivery of the NHS Wales Strategic Delivery Plan for Decarbonisation. Where opportunities exist, we are focusing procurement activities in reducing the carbon emissions from our supplier base and mandating the use of supplier Carbon Reduction Plans. The over-dependence on global supply chains continues to push carbon emissions associated with manufacturing and transport to levels that are not sustainable in the longer term. The work of the teams in supporting the establishment of domestic/onshored, low carbon manufacturing suppliers is a feature in the considerations and criteria regarding supplier selection. The following graphic provides a snapshot of the main emitters of CO₂ within our supply base and where focus needs to be provided.

Decarb – Top 40 suppliers by emissions



22

Looking Forward

The challenges from 2025/26 are very much still on the agenda for Procurement Services into 2026/27 and beyond. We will continue to work proactively and in partnership with your Health Board towards the delivery of these common goals and stand ready to support you in addressing any new challenges and opportunities that present themselves in the year ahead.

Diolch

Jonathan Irvine
Director of Procurement Services
NHS Wales Shared Services Partnership

BCUHB ANNUAL ASSURANCE REPORT

This report is intended to provide the Executive Director of Finance with an update on Procurement activity conducted on behalf of the Health Board during the financial year 2025/26, the areas covered in this report are:

1. Savings Position
2. Contracting position
3. Quotations
4. Waivers position (Issued, awarded & avoided)
5. Robotics Project progress
6. Transactional KPIs
7. Actionpoint activity
8. Customer Service & Transactional activity
9. Welsh Government Policy Progress updates
10. Procurement Training for Health Board Staff

1. Savings Position at end Q4

The HB procurement savings target of £2m full year effect cash releasing savings (equating to c£1m in year effect) was agreed with the HB Finance & Performance Lead in early 2025. The monthly savings returns for both Local and National Sourcing activity are sent to the HB Savings Accountant at the beginning of each calendar month, with the information subsequently being shared with each relevant HB Chief Finance Officer to analyse the financial impact on their localities.

BCUHB Procurement Savings at end of M12 (March 2026)	
	Actual
Cash Releasing (Revenue)	£2,014,627.29
Cost Avoidance (Capital & Revenue)	£5,105,808.24
Medicines Management Savings	£8,466,378.00
Energy Savings (Gas/Electricity)	£2,262,153.27

We are pleased to report that the Integrated Partnership Team exceeded its annual savings target for the HB by the end of Q4. The HB continues to operate in a challenging economic environment and Procurement Services is focused on ensuring that the Health Board is not adversely impacted by the unstable economic environment as a consequence of events in the Middle East. It is therefore really pleasing that the Procurement savings target has been exceeded and puts the team in a strong position to continue to deliver significant cash releasing and efficiency savings for the HB during the 26/27 financial year.

2. Contracts (Savings, Service delivery and governance)

Contracting activity is undertaken when expenditure for the procurement of goods & services required by Health Board Departments exceeds £25,000. All opportunities to bid for Health Board contracts over £25,000 are posted via the procurement e-tender portal 'Bravo'.

Suppliers interested in bidding for NHS Wales contracts should be directed to the 'Sell to Wales' website whereby they can register their interest in receiving alerts for any relevant opportunities to supply Welsh Public Sector organisations.

Contracts awarded

There has been significant contracting activity across the Health Board during the 25/26 financial year, with **158** contracts being awarded in total with a cumulative value of almost £96m as shown in the table below.

A further breakdown of the contracts awarded during the financial year is provided in the accompanying excel report (Appendix 1).

	No. Of Contracts Awarded above £25k	Value of Contracts Awarded
Q1	19	£37,709,938.80*
Q2	17	£17,273,973.25
Q3	59	£12,709,711.92
Q4	63	£27,866,744.19
Total:	158	£95,560,368.16

*Note: £36m of Q1 relates to the Outsourcing of a number of Surgical Specialities (including General Surgery, T&O and ENT).

It is important to note that over 75% of the above £25k contracts which were let on behalf of the Health Board during the 25/26 Financial Year were for schemes (such as Capital, Estates & IT) that would not deliver cash-releasing savings for the organisation. This means that although the majority of the Procurement Team's Workload was for contracts that were deemed 'business critical' for BCUHB, this significantly impacted the team's ability to improve on the cash-releasing savings position. This is a trend that is likely to continue into the 26/27 Financial Year.

Direct Award Contracts

Direct Award Contracts under Framework Agreements (either NWSSP agreements or 3rd party arrangements via the likes of NHS Supply Chain or the Government Commercial Agency) are fully contractually compliant procurements that allow HBs to award contracts for goods/services to a supplier who has been awarded a place on an overarching Framework Agreement. However, it can often be difficult to articulate whether the HB is achieving best value for money by awarding such a contract without testing the market (either via a competitive tender process or via a 'mini competition' exercise within a Framework Agreement).

Since 1st May 2025 NWSSP Procurement Services has been working with HB Finance Colleagues to reduce the number of Direct Award contracts that are awarded on behalf of the Health Board. The was to ensure enhanced scrutiny of proposed contracts that were to be awarded without competition and also to ensure value for money for the Health Board. The table below shows the number of Direct Award contracts that were placed by BCU in both the 24/25 FY and the 25/26 FY:

Financial Year	No. of Direct Award Contracts Awarded	Total Value of Direct Award Contracts awarded
24/25	126	£30,199,357.42
25/26	113	£49,371,691.65*

*Note: £36m of 25/26 spend relates to the Outsourcing of 8 Surgical Specialities (including General Surgery, T&O and ENT).

The above table shows that the use of Direct Award contracts is slowly reducing in both volume and value. It is anticipated that this number will continue to reduce over the course of the 26/27 FY.

Business Quality Internal Audit Programme

Each year, NWSSP Procurement Services Business Quality Team arranges a series of Internal Audit reviews to ensure that each Procurement Team across Wales is complying with the internal Policies & Procedures which cover all of the organisations procurement activities. Any 'non-conformances' or 'service improvements' are flagged to the relevant Head of Procurement for action, with re-audits taking place within a 3 month period to check on the team's progress against its improvement plan. The Internal Audit plan has been updated over the last few months to take account of Procurement Services' recently relaunched

'Document Management System', which outlines the standard operating procedures for all Procurement Teams across Wales.

An audit of the north Wales Integrated Partnership Team's Quotes, Tenders & Contract Management processes is due to be carried out by colleagues in NWSSP's Audit & Assurance Division in November 2026, the results of which will be shared with BCU Finance Colleagues in the Q4 Quarterly Report.

3. Multi Quote

It is normal practice to obtain three quotes for items of expenditure between £5,000 and £25,000 which aren't covered by an existing contract or framework.

Multiquote is an electronic portal used by Procurement Staff to post opportunities which invite prospective suppliers to quote for the supply of goods and services up to the value of £24,999 in line with SFIs.

The table below provides a summary of quotes awarded during financial year 2025/26 whilst these procurement exercises have delivered some savings, the process undertaken has more often been to confirm/refute the single supplier argument thus negating the need for a Single Quote Waiver.

	Quotes Awarded	Value of Quotes Awarded
Q1	29	£344,031.92
Q2	74	£917,543.27
Q3	73	£888,454.50
Q4	60	£728,424.85
Total:	236	£2,878,454.54

4. Requests to waive Standing Financial Instructions

It is normal practice to obtain three quotes for items of expenditure between £5,000 and £25,000, where this is not possible then a single quote waiver should be obtained and approved ahead of expenditure being committed.

For items of expenditure above £25,000 it is normal practice to request bids from multiple suppliers via the procurement e-tender portal 'Bravo'. 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:

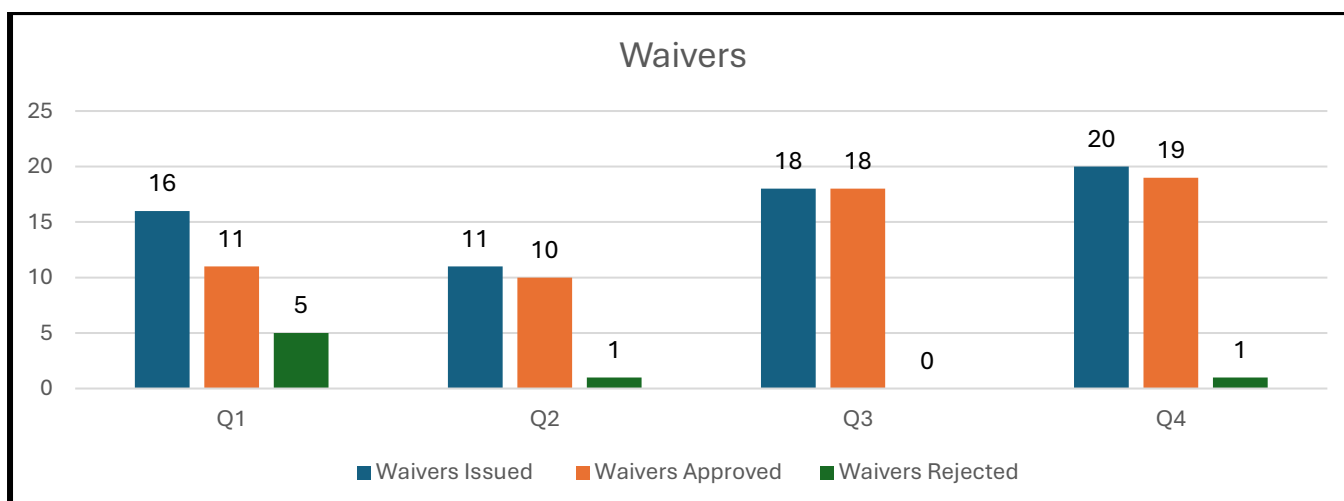
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition).
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause.
- A need to retain 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 period April 2025 to March 2026.

	Q1	Q2	Q3	Q4
Waivers Issued	16	11	18	20
Waivers Approved	11	10	18	19

Waivers Rejected	5	1	0	1
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The chart below provides a quarterly profile of the waiver activity for the 25/26 Financial Year.



The above table continues to show a reduction in the number of waiver requests issued and approved during the financial year. During 23/24 there were 149 waivers issued, 106 were approved and 26 were rejected. During 24/25 there were 103 waivers issued, 38 of which were approved and 14 were rejected. By comparison during the 25/26 FY the table above shows that 65 waiver requests were issued, 58 of which were approved and 7 were rejected. This downward trajectory in the number of waiver requests should continue during the 26/27 FY as Procurement Services continues to work with HB colleagues to firm up workplans and plan for future capital requirements.

5. Audit Committee Reportable Breaches (Previously File Notes)

A breach process has been implemented by Procurement Services to acknowledge and track retrospective spend that is considered a breach of Health Board SFI's. The purpose is to provide documentation that acknowledges these breaches and provides an audit trail to determine where and when the breach took place.

Repeated breaches will be reviewed by audit and will be investigated for consistent reasoning for breaches. The process is for retrospective/agreed spend only and should not be seen as a replacement to the waiver system.

The table below provides a summary of file note activity for 25/26

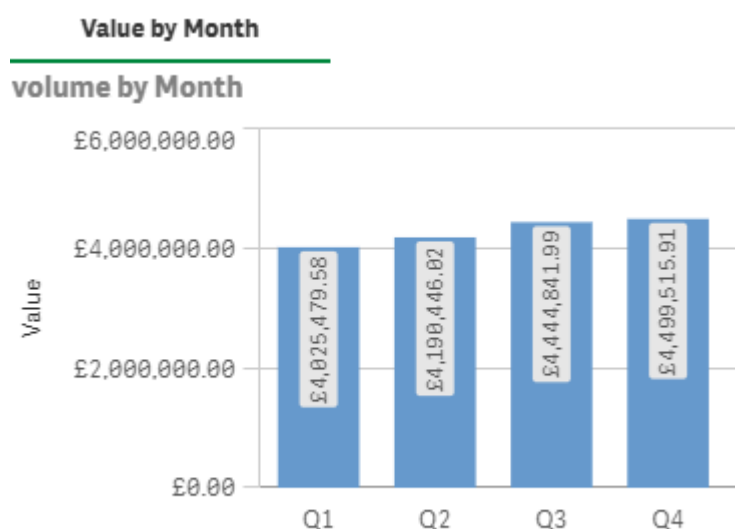
	No. Of ACRBs Raised	Value of ACRBs Raised
Q1	16	£642,519.22
Q2	32	£1,113,042.79
Q3	22	£2,621,491.43
Q4	17	£1,101,590.61
Total:	87	£5,478,644.05

The Audit Committee Reportable Breaches that were raised during the 25/26 FY are detailed in Appendix 1.

6. Project Progress - Supply X / Scan for Safety

Progress made throughout 25/26

The rollout of Scan for Safety and SupplyX across the Health Board continues, with the total number of requisition lines automated at 300,192 for the year, at a value of £17.16m. The graph below shows the continued expansion of spend coverage.



The ongoing management of areas already live with SupplyX as well as implementation in new areas realised efficiency benefits of £381,866 during 25/26.

Actions outstanding for BCUHB

The key ask from the original paper in 2024 remains outstanding: the Scan for Safety Team is seeking support from BCU to allow the already built patient feed to be tested and switched on to 'live' to allow products to be scanned to patients. This will allow full product traceability and allow BCU to prepare for compliance with the proposed Medical Devices (Amendment) regulations 2026 as drafted by MHRA and due in UK Parliament in December 2026. In addition, the enhanced traceability will enable more accurate patient level costing to be carried out across multiple specialities.

An Executive sponsor is to be sought to oversee a Task and Finish Group to ensure patient safety opportunities as well as increased benefits realisation are delivered during 26/27.

7. Transactional Activity Performance Indicators

These data sets relate to the All Wales KPIs for transactional activity undertaken by both Health Board (requisitioners) and Procurement staff when committing expenditure on behalf of the Health Board.

Requisitions are requests raised by Health Board staff and are categorised as either Catalogue or Non-Catalogue requests.

- Catalogue requests are predominantly 'on-contract' items used within NHS Wales which have been pre-loaded into Oracle for ease of ordering. Requests for these items automatically generate a purchase order once the requisition has passed through the approval hierarchy within Oracle.
- Non-Catalogue requisitions require buyer intervention either via the conducting of a multiquote exercise or further investigation and comparison with contracted lines available from other suppliers.

Catalogue coverage continues to increase steadily with on average 87.5% of expenditure via Oracle Purchase Order now automated due to increased contract coverage in relation to non-pay expenditure.

The Health Board continues to receive a significant amount of 'No PO No Payment' queries, with over 600 invoices per quarter being received without a valid purchase order. This impacts the Health Board's overall 'Invoice on Hold' position and increases the likelihood of supplier accounts being placed on hold due to delays in invoices being paid.

The number of Retrospective Purchase Orders raised by the Health Board has averaged 1000 per quarter, as can be seen in the table below. Retrospective Orders above £5k in value are reported by Finance colleagues to the Audit committee. Procurement staff are working with service users to educate them as to best practice and to re-emphasise the SFI requirements of raising a Purchase Order in advance of commitment to expenditure.

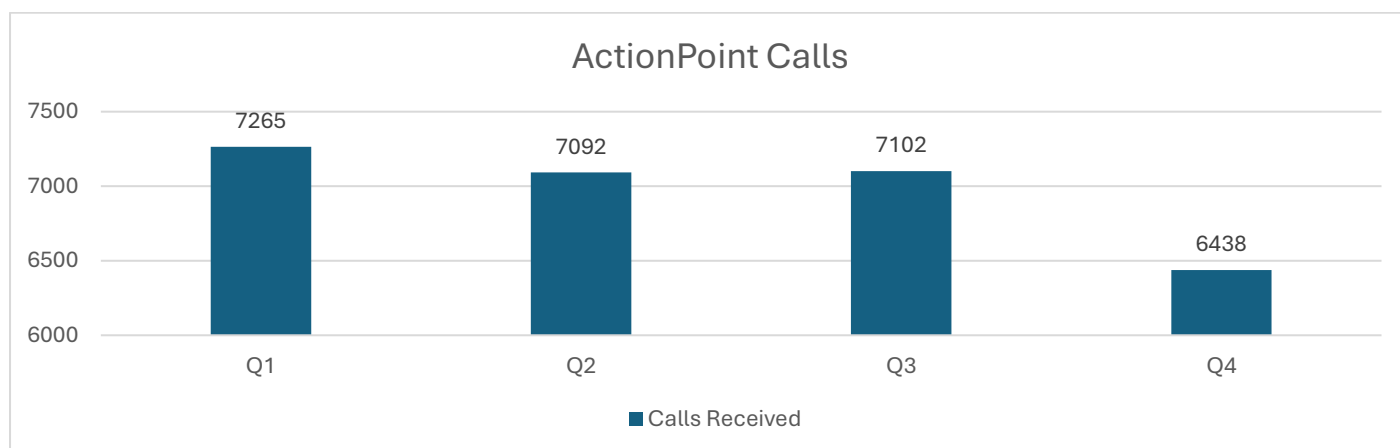
KPI Title	Definition/Target	Q1	Q2	Q3	Q4
Catalogue Coverage	<i>Increase catalogue coverage to meet All Wales target of 80%</i>	87.5%	86.7%	86.3%	87.4%
No PO No Payment	<i>Reduction in the number of manual invoices paid where it has been agreed to raise a PO (Figures are number of Invoices received with a valid PO)</i>	674	704	768	627
Retrospective Orders	<i>Reduce the number of retrospective orders raised</i>	978	1,018	984	940
Requisitions	<i>Requisitions turnaround within 3 days All Wales target of 90%</i>	68.1%	65.1%	73.1%	85.1%
Requisitions returned	<i>Requisitions returned due to lack of information, or the item was a catalogue line</i>	202	226	194	168

The requisition turnaround stats have steadily increased throughout the Financial Year due to the restructuring of Oracle approval hierarchies within the Health Board following the introduction of enhanced non-pay controls across the organisation during early 2024.

8. Action point customer calls received / responded to.

ActionPoint is the Procurement Teams customer service portal through which much of our communication with day-to-day service users is conducted. The portal is manned Monday to Friday and provides Health Board and Procurement Staff alike with an auditable trail on the incoming requests received by the team in terms of responsiveness and advice provided. The portal typically receives between 2,000 and 2,500 calls per month from our service users as is demonstrated in the table below. Calls fell slightly at the end of Q4 in part as Financial Year end crossed with the Easter Holiday break.

Q1	Q2	Q3	Q4
7,265	7,092	7,102	6,438



The team aim to resolve most calls within 24 – 48hrs depending on the nature of the incoming enquiry, the exception being calls requiring additional information from requestors and/or suppliers which can often take up to 5 working days to resolve. All calls in the above totals were addressed and closed by the end of each quarter.

The table below provides a summary of the Top 5 enquiry types by volume of calls received, most of the PO queries received in the first half of the Financial Year related to the expediting of requisitions that were pending action due to the enhanced change controls in place.

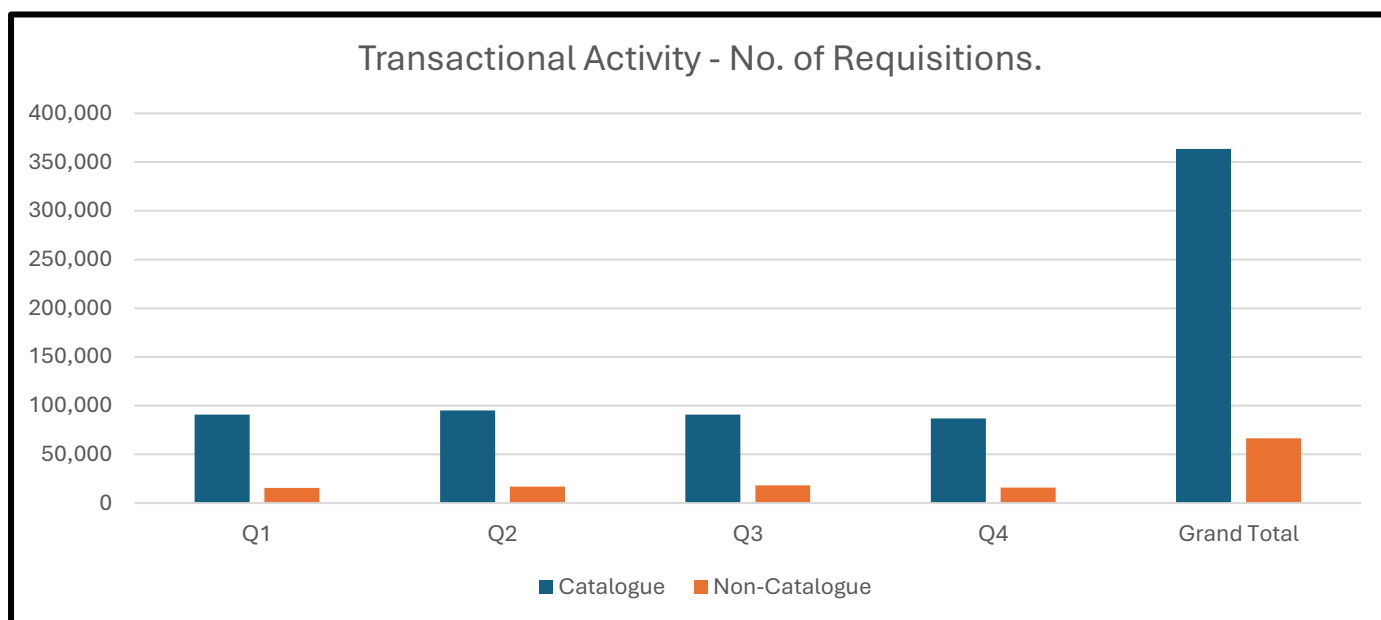
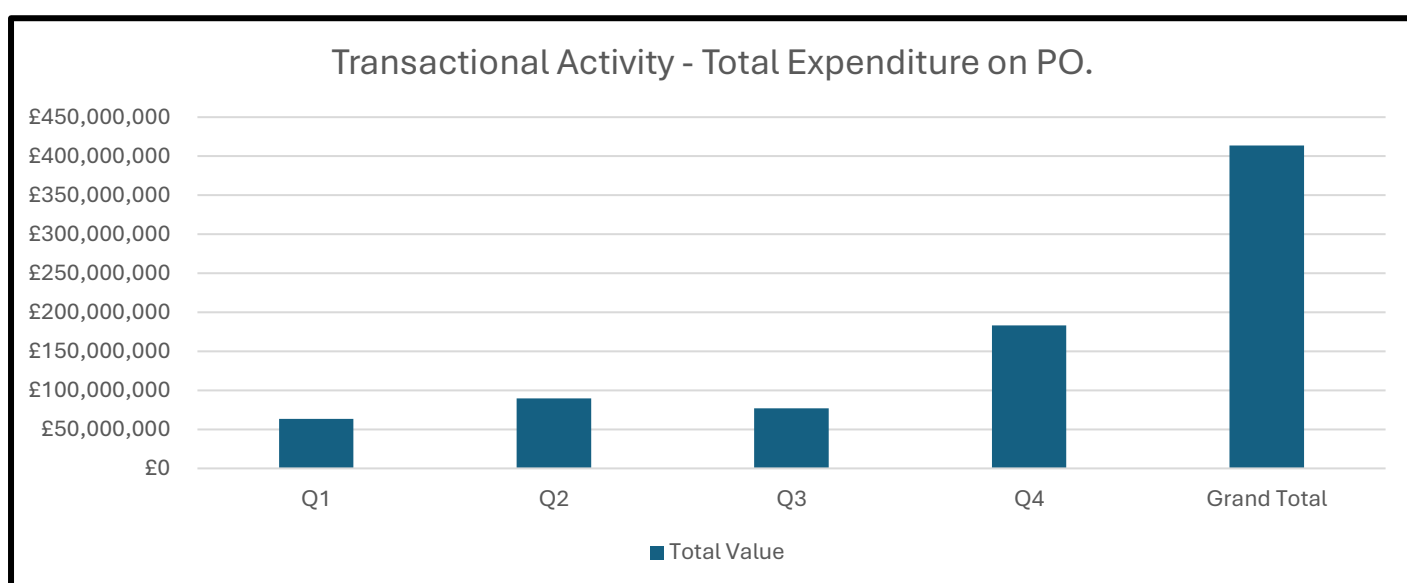
Enquiry Type	Q1 (APR - JUN)	Q2 (JUL - SEP)	Q3 (OCT - DEC)	Q4 (JAN-MAR)
	No. of calls	No. of calls	No Of Calls	No Of Calls
Purchase Order Query	2,501	2,927	2,748	2,391
Invoice on Hold	321	276	416	309
Supplier Notification or General Query	1,797	1,333	1,564	1,910
Product Enquiry	1,095	1,094	1,033	896
Awaiting Buyers Action	1,164	996	951	548
Grand Total	6,878	6,626	6,712	6,054

9. Customer Service & Transactional Activity

Transactional activity is predominantly activity undertaken in relation to non-catalogue requisitions received which require manual intervention by our buyers. Procurement services are working towards increased automation of purchase orders across the health board, the table below demonstrates that the percentage of non-catalogue lines fell to 13% in the final quarter of 2023/24, this figure is expected to continue to fall as our focus moves towards educating our service users with regards to alternative or similar items available on the existing catalogues and contracts.

	No. of Requisitions	No. of lines	% of Catalogue lines	% of non-catalogue lines	No. of Purchase Orders	No. of Suppliers	Total Expenditure on PO
Q1	31,267	106,650	85.3%	14.7%	41,075	1,756	£63,597,791.97
Q2	32,705	111,934	84.9%	15.1%	42,751	1,878	£89,778,452.17
Q3	31,734	108,915	83.4%	16.6%	41,766	1,903	£76,886,386.34
Q4	30,258	102,583	84.6%	15.4%	39,894	1,782	£183,345,636.70
Total:	125,964	430,082	84.55%	15.45%	164,486	7,319	£413,608,267.18

The graphs below show the full year profile of transactional activity.



10. Welsh Government Policy Progress Update

NWSSP is responsible for ensuring that Welsh Government's key policy areas are considered during all of our day-to-day procurement activity for BCUHB. This includes policies such as the Well Being of Future Generations, Foundational Economy, Sustainability, Social Value and Decarbonisation. This information is reported into Welsh Government monthly.

The table below provides the Health Board with brief headlines on projects linked to the delivery of the above policies affecting procurements conducted on behalf of the Health Board.

WG Policy	Progress update
Foundational Economy	41 contracts awarded to Welsh Suppliers – total value £10,698,864.31
Decarbonisation	20 Contracts awarded during the 25/26 FY which have Decarbonisation benefits to the Health Board – total value of these agreements is c£56m. This includes the following contracts:

	<ul style="list-style-type: none">• North Wales Cancer Treatment Centre Linac Replacement Works• YG Gamma Camera & Fluoroscopy Replacement Works• Fire Door Upgrades at Llandudno Hospital• Helipad Works at Ysbyty Gwynedd
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11.Procurement Training for Health Board Staff

Procurement Services working in collaboration with BCU Finance and Counter Fraud colleagues have continued the delivery of a rolling programme of Procurement Awareness Sessions for budget managers across the Health Board during 25/26. A training session was also held for the Health Board Executive Team in December '25 with a specific focus on the changes to UK Procurement legislation following the implementation of the UK Procurement Act in early 2025.

Report Produced for Betsi Cadwaladr University Health Board on behalf of NWSSP Procurement Services by:

Jonathan Irvine, Director of Procurement Services

Wyn Owens, Head of Operational Procurement & National Sourcing

Date: 18th September 2026



Audit Committee

INTERNAL AUDIT PROGRESS REPORT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dave Harries, Head of Internal Audit, CMIA Nicola Jones, Deputy Head of Internal Audit, CMIA
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol **Executive Summary**

The progress report summarises seven reviews finalised since the last Committee meeting in August 2026, with the recorded assurance as follows:

- Substantial assurance – one.
- Reasonable assurance – three.
- Limited assurance – two.
- Advisory/Assurance not applicable – one.

A change to the agreed plan is requested through the deferment of the Commissioned Services – Specification & Performance (BCU-2627-16).

We identified a risk relating to exit procedures for executive directors after evidence showed that a former executive director's username remained active in the Oracle E-Financials approval hierarchy after they had left the Health Board.

We have raised a potential financial risk with the Finance Directorate concerning care home late payment fees/interest charges where some nursing agencies have ceased trading.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
AI	Artificial Intelligence
COO	Chief Operating Officer
IA	Internal Audit
IIA	Institute of Internal Auditors
IMTP	Integrated Medium Term Plan
ITIL	Information Technology Infrastructure Library
NHS	National Health Service
RAH	Royal Alexandra Hospital
SFI	Standing Financial Instructions
TBC	To Be Confirmed
TEF	Targeted Estates Fund
UEC	Urgent and Emergency Care
UK	United Kingdom

INTERNAL AUDIT PROGRESS REPORT

1. Y SEFYLLFA SITUATION

- 1.1 The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing Internal Audit Assignment reports.

2 Y CEFNDIR BACKGROUND

- 2.1 The report provides details of audit reports issued as final and the status of the agreed 2026/27 internal audit plan.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

- 3.1 Two limited assurance reports have been issued in the period: Health and Safety Compliance and Foundations for the Future – Project delivery.
- 3.2 Changes to the agreed plan are requested through the deferment of the Commissioned Services – Specification & Performance. Following issue of the brief for approval, we were requested to delay the review into quarter 4 2026/27 at the earliest, as the framework continued to be implemented. As management continue to implement and embed the framework, completing the review would not establish whether the expected controls are embedded.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

- 4.1 We have identified risks relating to:
- Exit controls concerning the end-dating of user access within Oracle E-Financials following the departure of an executive director where their username continued to appear active.
 - Care Home Late Payment Fees/Interest charges where some nursing agencies have ceased trading, their historical order books/debt have been purchased by private claims management companies.

5 ARGYMHELLION RECOMMENDATIONS

- 5.1 The Committee is asked to:
- **Note** the findings within the progress and associated audit reports.

-
- **Approve** deferment from the 2026/27 internal audit plan of the Commissioned Services – Specification & Performance review.



ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	1. building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Wise Spending Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	N/A other than those relating to individual audit reviews / recommendations.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Equality duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and 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).
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<p><i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i></p> <p>Socio-Economic Impact Assessment</p> <p><i>Have you undertaken a Socio-Economic Impact Assessment</i></p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>The Socio-Economic duty is not applicable.</p> <p>The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).</p>
<p><u>Ansawdd</u></p> <p><i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i></p> <p><u>Quality</u></p> <p><i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p>Galluogwyr Ansawdd Enablers of Quality All Apply</p>	<p>Meysydd Ansawdd Domains of Quality All Apply</p>
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u></p>	Not Applicable	

<p>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	
	No - Not Applicable	
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:</p>	
<p>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</p>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<p>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?</p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>The Armed Forces Covenant Due Regard duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).</p>
<p>Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	<p>Do/Yes: ☐</p>	<p>Naddo/No: ☒</p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>There is no identifying information included in the progress report or reports.</p>
<p>Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i></p>	<p>Do/Yes: ☒</p>	<p>Naddo/No: ☐</p>
	<p>Canlyniad/Outcome:</p>	<p>Counter-fraud considerations are incorporated into all relevant audit reviews.</p>
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	
<p>Cyfreithiol Legal</p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	
<p>Enw Da Reputational</p>	<p>There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.</p>	
<p>Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i></p>	<p>There is no direct impact on resources as a result of the activity outlined in this report.</p>	

Internal Audit Progress Report

Audit Committee

1 August to 7 October 2026

Betsi Cadwaladr University Health Board

Contents

Introduction	1
Reports Issued	1
Follow-up	2
Contingency/Health Board support/Advice	2
Delivering the plan	3
Appendix A	7

Introduction

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 2026/27.

Reports Issued

Since the last progress report, seven reviews have been issued as final.

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
Health and Safety Compliance (BCU-2627-03)	Limited	Whilst corporate arrangements and the refreshed self-assessment process provide a developing framework for compliance, there are matters requiring management attention in relation to governance, communication, policy alignment and role-specific training.
Foundations for the Future – Project delivery (BCU-2627-04)	Limited	The review identified significant weaknesses in programme governance, delivery oversight, risk management and reporting arrangements for a programme of such significance.
Integrated Medium Term Plan (IMTP) and Annual Plan (BCU-2627-07)	Reasonable	The review found a documented planning timetable aligned to national requirements; questionnaire feedback from key officers noted concerns regarding communication, ownership, accountability and deliverability.
Delivery of Savings (BCU-2627-12)	Reasonable	The review found effective governance, management, and reporting arrangements in place although we found underdeveloped arrangements for recovery planning and the consistent monitoring, escalation and evaluation of corrective actions for underperforming schemes.
Suicide Prevention (BCU-2627-18)	Reasonable	With the Health Board actively contributing to regional suicide prevention arrangements, there is a need to clarify operational leadership arrangements, develop a local implementation plan, and strengthen consolidated reporting to provide clearer Board-level assurance.
Cyber security (BCU-2627-20)	Substantial	The Health Board has generally effective arrangements for managing cyber security risks, supported by governance, risk management and improvement planning processes.
Space Utilisation (BCU-2627-31)	Advisory	Arrangements for managing space utilisation across the Health Board are currently inconsistent, with no clear Health

		<p>Board-wide governance framework, reporting structure, or comprehensive approach to collecting and using utilisation data.</p> <p>Work is required to strengthen strategic oversight, improve data-driven decision-making, and support more effective use of estate resources across the Health Board.</p>
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Image 1: Summary of final report assurance ratings issued as of 8 October 2026

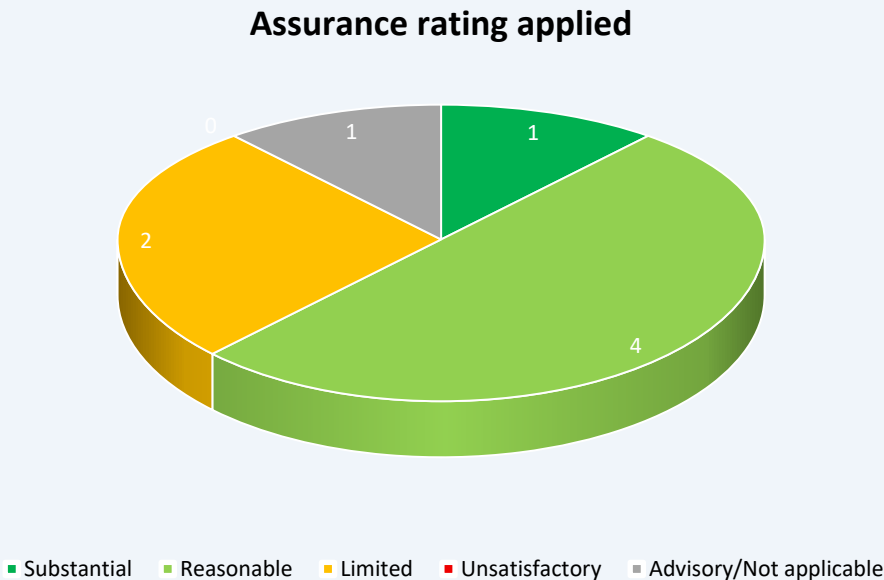


Table 4 details the status of all reviews in the 2026/27 plan.

Follow-up

The Corporate Governance Directorate provides Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure.

No follow-up reviews have been completed in this reporting period.

We have developed a proposal for the Health Board to bring follow-up reviews in line with the rest of NHS Wales. Once agreed by the Accountable Officer and Director of Corporate Governance, we will bring to the Committee for ratification.

Contingency/Health Board support/Advice

Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

We have met with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

We have attended and observed the Risk Scrutiny and Executive Policy Oversight Groups in this reporting period, coupled with attending/observing the Health Board and its Committees. We have also provided our advice for the change in process for approving new Oracle users.

We have met with the Director of Corporate Governance in this reporting period.

Scheme of Reservation and Delegation

On the 27 August 2026, we were contacted by a Health Board senior officer concerning the approval of Oracle E-financials requisitions appearing to still include the former Chief

Operating Officer (COO) in the approval hierarchy. As the COO’s last working day was the 14 August 2026, the evidence provided to us showed approval by the COO post their last working day.

We raised the matter with the Director of Corporate Governance as it was unclear how the username was still being used and considered this represented significant financial risk; we confirmed with Business Systems that no vacation rule was in operation, therefore suggesting that the access was made using the username and password of the former COO.

In reviewing the Standing Financial Instructions, it would appear that SFI 10.1.3 was not being complied with: *10.1.3 The Chief Executive will set out in the operational scheme of delegation and authorisation: • The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts.*

The Director of Corporate Governance did raise the matter with officers but we are unclear on the outcome coupled with clarity on all requisitions approved under the former COO’s username, post 14 August 2026, and whether they were subject to further scrutiny and consideration in line with the Scheme of Reservation and Delegation.

Risk awareness - Care Home Late Payment Fees/Interest charges

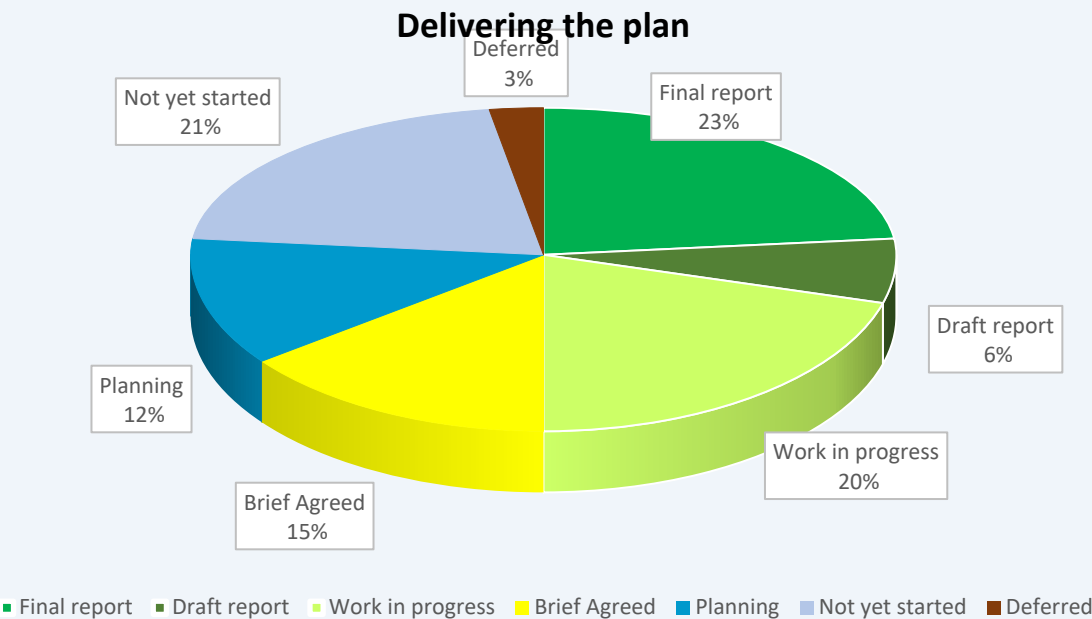
On the 15 September 2026, we highlighted a potential financial risk arising from a recent issue discussed at another Health Board’s Audit Committee.

We advised management of a risk that where some nursing agencies have ceased trading, their historical order books/debt have been purchased by private claims management companies. While invoices, including some dating back approximately six years, were paid in line with the Public Sector Payment Policy, the receiving agencies sometimes recorded funds into their bank accounts on day 31 or 32. As a result, the claims management companies are now reviewing historical transactions and, where applicable, issuing late payment charges, including fixed fees (for example £40, £50, £100) plus 8% interest, which are now being billed to at least two Health Boards at the time of this report.

Delivering the plan

The status of the 2026/27 plan is detailed in image 2, with further details in Table 4.

Image 2: Status of plan delivery – 2026/27 (excluding Committee approved deferrals)



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

As new risks are identified in year, the Director of Corporate Governance and Head of Internal Audit will consider the planned reviews against the emerging high-level risks.

The Audit Committee is requested to approve the changes to the audit plan outlined in the table below.

Table 2: Changes to the 2026/27 internal audit plan

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
Commissioned Services – Specification & Performance (BCU-2627-16)	<p>Following issue of the brief for approval, we have been requested to delay the review into quarter 4 26/27 at the earliest, as the framework is being implemented. Undertaking a review as the framework continues to embed will not establish whether the expected controls are operating as outlined.</p> <p>Recommendation: This review is deferred for consideration as part of risk planning for the 2027/28 plan.</p>

The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4).

Table 3 is reporting positive status across four of the five indicators; report turnaround time has decreased from 64% to 50% and is based on a comparatively small number of reports. We recognise the capacity within the Executive team due to recent vacancies is impacting turnaround times. Figures are based on reports issued as final.

Table 3: Performance Indicators (2026/27)

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2026/27		21 April 2026	30 June
Total audit reviews reported against adjusted plan for 2026/27		34	34
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100%	95%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		50%	85%
Report turnaround: time from management response to issue of final report [10 days]		100%	95%

Key:  v>20%  10%<v<20%  v<10%

Table 4: Core Plan 2026/27

Planned output	Status	Planned Committee Meeting ¹	Assurance rating ²
01. Sickness management – corporate directorates (carry over from 2025/26)	Final report.	August 2026	Reasonable
02. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub (carry over from 2025/26)	Draft report issued.	December 2026	
1. Risk Management and Board Assurance Framework	Not started.	April 2027	
2. Follow up	Work progress. in	On-going	
3. Health and Safety Compliance	Final report.	October 2026	Limited
4. Foundations for the Future – Project delivery	Final report.	October 2026	Limited
5. Foundations for the Future – Operational governance and accountability	Not started.	June 2027	
6. Implementation of Ministerial Directives.	Work progress. in	December 2026	
7. Integrated Medium Term Plan (IMTP) and Annual Delivery Plan	Final report.	October 2026	Reasonable
8. Accountability and Performance Management	Brief agreed.	April 2027	
9. Value and Sustainability – project governance and clinical variation	Work progress. in	December 2026	
10. Private Practice	Work progress. in	October 2026	
11. Budgetary Control and Financial Reporting	Draft report issued.	October 2026	
12. Delivery of Savings	Final report.	October 2026	Reasonable
13. Quality Management System	Not started.	June 2027	
14. Clinical Audit	Brief agreed.	February 2026	
15. Medical Devices	Brief agreed.	April 2027	
16. Commissioned services – specification and performance	Recommended for deferral.	February 2027	
17. Research and Development	Deferred.	-	-
18. Suicide prevention	Final report.	October 2026	Reasonable
19. Skills and Capabilities	Work progress. in	December 2026	
20. Cyber Security	Final report.	October 2026	Substantial
21. Service Implementation (ITIL)	Brief agreed.	April 2027	

¹ Subject to change.² Assurance rating for draft reports is included where the timeline for factual accuracy issues has passed.

Planned output	Status	Planned Committee Meeting ¹	Assurance rating ²
22. Artificial Intelligence (AI) – governance and control	Not started.	June 2027	
23. Planned Care delivery – validation	Planning.	TBC	
24. Urgent and Emergency Care (UEC) – verifying UEC flow	Planning.	April 2027	
25. Continuing NHS Health Care – Compliance with the National Framework	Brief agreed.	February 2027	
26. Primary Dental Care	Not started.	April 2027	
27. Violence and Aggression	Work progress. in	December 2026	
28. Culture (Advisory)	Planning.	April 2027	
29. Statutory Compliance: Water safety	Not started.	June 2027	
30. Management of leases	Planning.	June 2027	
31. Space Utilisation (Advisory)	Final report.	October 2026	Advisory
32. Capital Systems - Targeted Estates Fund (TEF)	Work progress. in	February 2027	
33. Integrated Audit and Assurance Plans	Not started.	TBC	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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Betsi Cadwaladr University Health Board – Audit Committee Update

Date issued: October 2026



Contents

Contents	2
Introduction	4
Accounts audit update	5
Performance audit update	6
Other relevant publications	8
Further information	9

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Introduction

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 (the Health Board). We presented our Audit Plan to the committee in April 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Completed
- **Committee date:** 23rd June 2026.

Audit of the 2025-26 Awyr Las Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2025-26 Audit of Awyr Las Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** January 2027.

Performance audit update

Deep dive review of the arrangements to manage estates

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** This work examined the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Complete
- **Expected committee date:** October 2026.

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work followed on from the review of national leadership arrangements for cancer services. The review considered the Health Board's approach to managing cancer services. This included how it plans services, prevents cancer, supports early detection and leads and oversees service performance.
- **Status:** Complete
- **Expected committee date:** October 2026.

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations.
- **Status:** Fieldwork
- **Expected committee date:** December 2026.

**Local work – Operating Theatre efficiency and effectiveness
(Note that this is a change from the plan and replaces our audit work on Foundations for the Future).**

- **Executive Lead:** TBC
- **Focus of the work:** This work will focus on the management of operating theatres and the extent that arrangements support efficient, effective and good quality services. We will consider progress with effective job planning for consultant surgeons and anaesthetists within the review.
- **Status:** Planning
- **Expected committee date:** March 2027

Primary Care follow up of recommendations

- **Executive Lead:** Interim Chief Operating Officer
- **Focus of the work:** This work will primarily on from my previous Review of Primary Care. We will consider progress in this area as part of my wider work to track progress of previous recommendations.
- **Status:** Planning
- **Expected committee date:** March 2027.

Review of the management and prevention of diabetes

- **Executive Lead:** Medical Director
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.
- **Status:** Planning
- **Expected committee date:** April 2027.

Other relevant publications

Since the last committee update, the Auditor General has not published other relevant outputs which have relevance to the NHS.

Audit Wales is current consulting on proposals for fee rates and other aspects of the statutory fee regime for audit work. The closing date for this consultation is the 18 September 2026.

Consultation on Fee Scales 2027-28

August 2026

Further information

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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



Are cancer services improving?

Betsi Cadwaladr University Health Board

September 2026

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Contents

Audit snapshot	4
Key facts and figures	7
Our findings	8
Recommendations	26
Appendices	28
1 About our work	29
2 Key terms in this report	31
3 Management response form	33

Audit snapshot

What we looked at

- 1 We looked at Betsi Cadwaladr University Health Board's (the Health Board's) approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.
- 2 We also reviewed trends in cancer service performance. Our 2025 [national report on cancer services](#) highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review

Why this is important

- 3 Demand for cancer services is increasing, driven by factors such as:
 - an ageing population;
 - rising levels of obesity and alcohol use;
 - better survival rates, meaning patients need ongoing follow-up and monitoring; and
 - the ongoing introduction of new tests and treatments.
- 4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.
- 5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

- 6 Access to cancer services remains well below the national standard. In March 2026, 54% of patients started treatment within 62 days of cancer first being suspected. The Health Board was once among the better performers in Wales but is now among the worst. As a result, many patients are waiting too long to start cancer treatment.
- 7 The Health Board has put recovery actions in place, but these have not led to sustained improvement. Progress relies heavily on temporary measures, such as insourcing and overtime. The Health Board mainly uses data to monitor current performance. It makes less use of data to predict demand, plan capacity and guide investment.
- 8 The Health Board provides prehabilitation support before, during and after cancer treatment. However, access to these services varies across sites. The Health Board does not always use learning from this work to improve services.
- 9 Senior leaders closely monitor cancer services, and staff work across teams to address delays. However, most effort focuses on current performance issues rather than long-term improvement. The Health Board does not have a single, costed plan for cancer services. As a result, it is not clear how it will address prevention, staff shortages, limited diagnostic capacity, ageing equipment and rising demand.
- 10 The Health Board knows that many cancers can be prevented. However, cancer leaders focus mainly on waiting times and performance. Prevention and early diagnosis are not given the same priority.

What we recommend

- 11 We have made six recommendations to the Health Board in the following areas:
 - developing a costed integrated cancer strategy and delivery plan;
 - monitoring the delivery of the plan;

- improving demand and capacity forecasting;
- establishing a long-term workforce and infrastructure plan to create the capacity to meet current and future need;
- developing a sustainable cancer prevention programme; and
- strengthening the Cancer Board.

Key facts and figures



The number of new suspected cancer referrals rose by 6% between 2022–23 and 2025–26.



The spend on cancer services increased from £135 million to £188 million between 2019–20 and 2023–24. This is £28 million more than if spend had increased with inflation over the same period.



In March 2026, most referrals were for suspected skin cancer (969), lower gastrointestinal (735) and upper gastrointestinal (595) cancers.



In March 2026, 54% of patients started treatment within 62 days, compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 69.4% for skin cancer to just 40% for lower gastrointestinal cancer, against the 75% target.



Between 2002 and 2024 one-year cancer mortality rates have fallen by 16.2%.

Our findings

Cancer service improvement planning

Cancer plans are spread across different documents. There is no clear long-term plan to improve services, increase capacity or meet rising demand.

Cancer improvement plans

- 12 The Health Board has several plans for cancer services. The Cancer Roadmap (2024–2029) sets out its main aims. Other plans focus on reducing waits, improving cancer care and supporting services such as dermatology, breast, colorectal and urology. The Integrated Medium-Term Plan (IMTP) also includes actions to improve diagnostics, staffing and service capacity. However, there is no single consolidated plan that brings all of this work together and shows how services will improve over time. While cancer priorities are set out across several plans, it is not clear how these plans work together to manage long-term risks and improve services.
- 13 The Suspected Cancer Pathway (SCP) Delivery Plan sets out the Health Board's priorities for improving performance against the SCP target to start treatment within 62 days of first suspicion of cancer. The plan focuses on reducing pathway delays by increasing diagnostic and treatment capacity. However, many actions rely on short term measures, such as insourcing and overtime. The plan also does not set out the workforce, funding and infrastructure needed to sustain improvement. Actions to reduce inequalities are not a clear part of the plan.

- 14 The Health Board uses National Optimal Pathways¹ to check whether patients move through cancer services in a timely way. It reviews how well services follow these pathways. However, planning assumptions are often too optimistic. Some recovery plans include clear actions and named leads, but this is not consistent. Plans do not always show when actions will be completed or how they will improve services.
- 15 The Health Board works closely with hospitals in North-West England to provide cancer care. However, its plans do not clearly explain this dependency or how it affects service delivery. Plans also provide limited detail on how the Health Board oversees the quality and outcomes of care provided by other organisations. There is also limited evidence that the Health Board routinely uses learning from previous improvement work or best practice to shape future plans.

Cancer intelligence and data

- 16 The Health Board needs to make better use of cancer data and intelligence. It uses data on pathway performance, long waits, differences between tumour sites, diagnostic delays and demand from screening services to manage current pressures. This helps staff understand where problems exist and manage services day to day.
- 17 However, the Health Board makes limited use of data to predict future demand, plan capacity or support long-term improvement. Also, the way services use data is not consistent across the Health Board. Some services, such as dermatology, breast and urology use data to support planning and improvement, while others use it mainly to manage day-to-day pressures. As a result, the Health Board is missing opportunities to improve planning, make best use of capacity, and respond to future demand.

¹ Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

Supporting fragile services

- 18 The Health Board understands the main challenges facing cancer services and knows which services perform poorly. These challenges include staff shortages, delays in testing, ageing equipment and limited facilities. However, the level of risk varies between services and across North Wales.
- 19 The IMTP, Cancer Service Plan, SCP Delivery Plan and tumour-site plans all highlight cancer services risk. However, many actions focus on short-term fixes, such as extra clinic sessions, temporary staff and waiting list initiatives. These actions help services cope with current pressures, but they have not led to lasting improvement in cancer performance.
- 20 Some planned changes aim to help patients get diagnosed and treated more quickly. These include straight-to-test services, nurse-led triage and teledermoscopy. The Health Board is also helping more patients prepare for treatment through prehabilitation and receive radiotherapy closer to home. The changes have potential to deliver benefits in the longer-term. However, many are at an early stage, and it is too soon to know whether they will reduce current pressures and provide a sustainable solution. While some actions relate to longer-term solutions, these are often still being developed or depend on uncertain future funding and recruitment.
- 21 The Health Board works with partner organisations to help meet demand for cancer services. In the West, dermatology services rely on insourced staff because there are not enough permanent staff. The Health Board also works with specialist centres in North- West England so patients can receive specialist treatment.

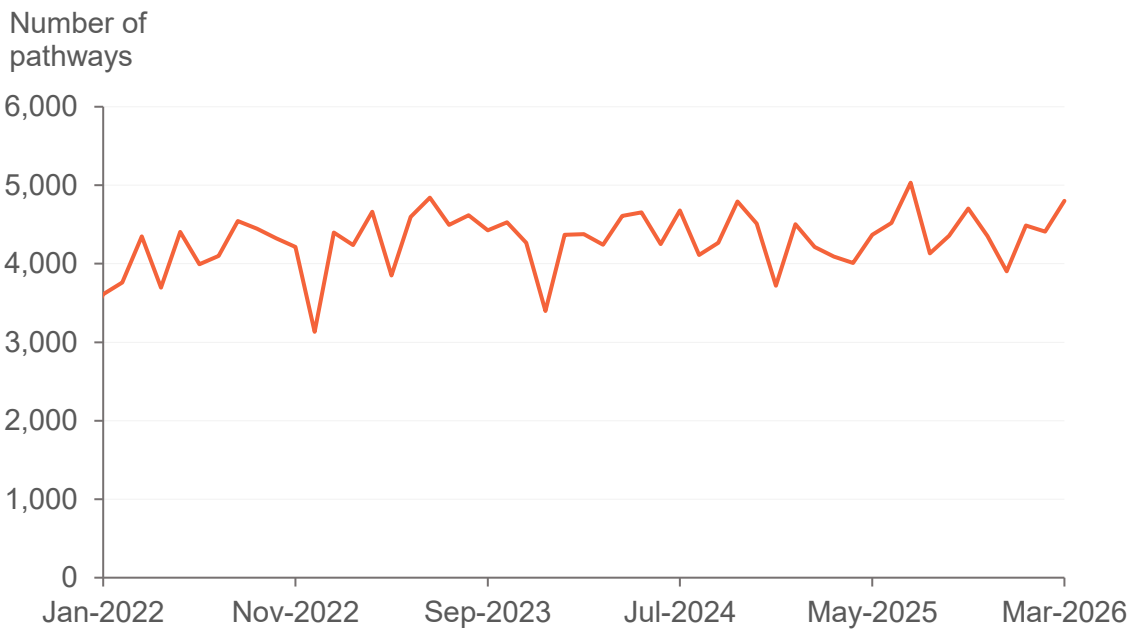
Financial and wider resource planning

There is no clear, balanced, financial or wider resource plan for cancer services

Funding plans

- 22 The Health Board has not identified the total funding that it needs to deliver its cancer improvement plans. Instead, it relies on individual business cases and short-term funding to support service developments. This makes it difficult to understand the full cost of improving cancer services and meeting national standards and targets. It may also mean that the Health Board will not be able to sustainably fund all planned improvements.
- 23 The IMTP includes funding to improve cancer services. This includes diagnostics, radiotherapy and more staff capacity. Funding comes from several budgets, so it is hard to see the total spend on cancer services. Some proposals still need national funding and business case approval before work can start.
- 24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows a slow but ongoing increase in demand. Changes in demand are not uniform across services though. The Health Board has seen a notable increase in referrals between 2022–23 and 2025–26 in urological (+21%), head and neck (+20%), and gynaecological (+19%) cancers.

Exhibit 1: newly opened suspected cancer pathways, Betsi Cadwaladr University Health Board, January 2022 to March 2026 (numbers).

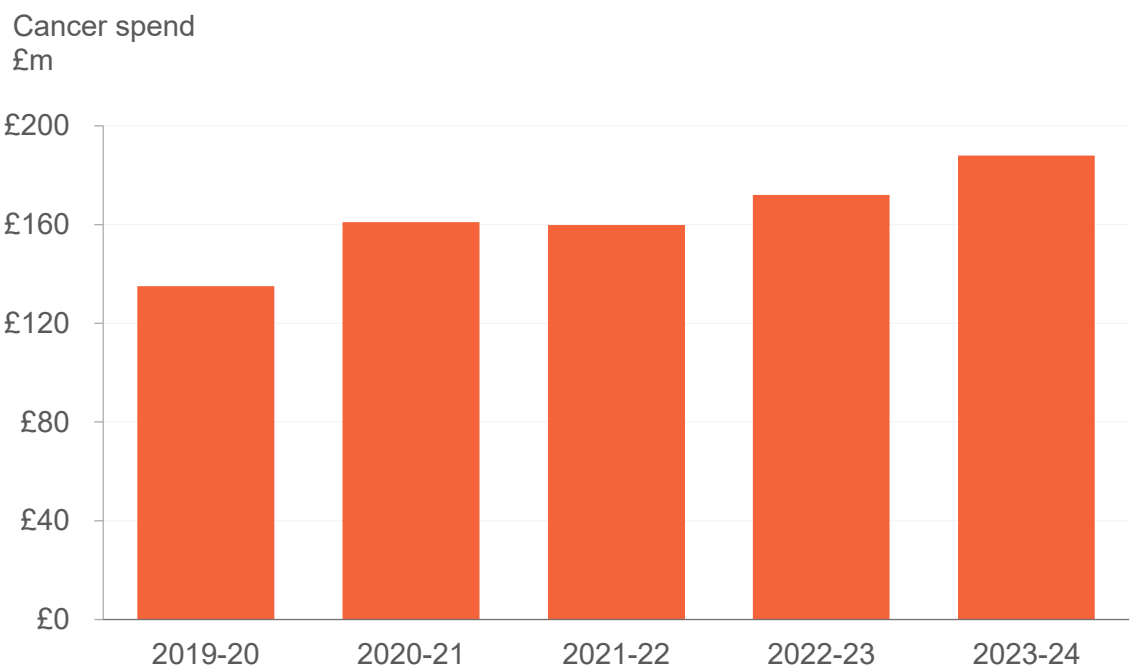


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient dies. Note that patients can be on more than one pathway.

- 25 New demand is increasing and the costs have increased faster than inflation. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board’s cancer spending rose by about 17% above inflation². Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, the Health Board’s spend rose from £135 million to around £188 million³⁴. This is about £28 million more than if costs had increased in line with inflation (in 2023–24 prices).
- 26 The expenditure analysis is based on the cancer expenditure dataset reported to Welsh Government and should be interpreted as an indicator of overall spending trends.

Exhibit 2: actual cancer services spend, Betsi Cadwaladr University Health Board, 2019–20 to 2023–24, (£million)



² Inflation is calculated using 2023–24 as a baseline and HM Treasury inflation data.

³ Some specialty medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

⁴ Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

Source: Audit Wales analysis of the Health Board's data, sourced from the Welsh Government

- 27 **Exhibits 1 and 2** show that spending has increased alongside rising demand. They also show that spending has grown faster than inflation, increasing the importance of effective financial planning. This limits assurance that cancer services will remain affordable and sustainable over the longer term.
- 28 There is evidence that services use financial information to support planning. This includes forecasts, staffing costs, other running costs, savings plans and known financial pressures. However, the Health Board has not brought this information into a single, costed plan for cancer.

Wider resourcing requirements

- 29 The Health Board understands the main challenges facing cancer services. These include staff shortages, limited space, ageing equipment and gaps in services such as robotic surgery. These issues are recognised in the IMTP, Cancer Roadmap and tumour-site plans. However, these plans provide limited detail on future demand, resource needs and delivery timescales. While key requirements are identified, it is not clear how the Health Board will address them in a joined-up way or manage the long-term risks facing cancer services.
- 30 The Health Board uses tools such as teledermoscopy, Chemocare and electronic triage to support cancer services. However, many systems do not link well together. Staff still use spreadsheets and enter data by hand. The Health Board plans to introduce new systems, including electronic patient records and digital diagnostics. These projects aim to reduce pressure on services and improve performance.
- 31 Teams across cancer services, diagnostics and surgery work together to improve care. This has led to nurse-led triage, straight-to-test pathways and changes to multidisciplinary team working. The Health Board also works with specialist centres in North-West England so patients can access treatments that are not available in North Wales.

Cancer prevention and population screening

The Health Board is not maximising the benefits of cancer prevention or using data effectively to take targeted action or improve screening uptake

32 The All-Wales Cancer Improvement Plan sets out that 38% of cancers each year are preventable. For context, if the Health Board prevented 20% of cancers, this could have saved £2.6 million in bed day costs⁵. **Exhibit 3** gives an example of potential gains if the Health Board successfully implemented a cancer prevention strategy.

Exhibit 3: potential capacity gains from cancer prevention, Betsi Cadwaladr University Health Board, based on 2024–25 activity

		2024-25 actual	-10% reduction	-20% reduction	-38% reduction
	Finished consultant episodes	23,450	21,105 (2,345 reduction)	18,760 (4,690 reduction)	14,539 (8,911 reduction)
	Admission episodes	22,632	20,369 (2,263 reduction)	18,106 (4,526 reduction)	14,032 (8,600 reduction)
	Bed days	26,581	23,923 (2,658 reduction)	21,265 (5,316 reduction)	16,480 (10,101 reduction)
	Bed day cost savings		(£1.3 million)	(£2.6 million)	(£5.0 million)

⁵ Based on 2024-25 activity data, and the most recent current financial data.

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Notes:

- 1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.
- 2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our [2025 National Cancer Services Report](#).

Public health risk assessment

- 33 The Health Board understands the main factors linked to cancer, including smoking, excess weight, poverty and unequal access to care. It uses this information to target support, including help to stop smoking, manage weight, and increase vaccination and screening uptake. However, the Health Board is not making enough use of this data to plan for future demand. As a result, planning focuses more on current pressures than future needs.
- 34 The Health Board is working closely with its Public Health Directorate, alongside Public Health Wales NHS Trust, to understand local health needs. However, cancer forums focus mainly on current demand, long waits and cancer treatment targets. They don't give enough attention to prevention and early diagnosis.

Approaches to improving population lifestyles

- 35 The Health Board provides services to help reduce the risk of cancer. These include supporting people to stop smoking, manage weight, increase vaccination uptake and improve healthy lifestyles. However, limited funding and competing demands reduce the reach and impact of these services.

- 36 The Health Board is targeting some services at people most at risk of cancer, and some have achieved good results. For example, smoking cessation services, which have exceeded national targets. However, limited funding and staff shortages restrict what these services can achieve. Many programmes rely on short-term funding, making it hard to plan for the future. The Health Board does not always use learning from this work to develop long-term funded plans.
- 37 Data shows that screening does not always help patients get diagnosed and treated quickly. Delays are common in bowel and breast cancer services, where increasing demand, diagnostic capacity constraints, workforce shortages and wider service pressures mean patients do not always receive follow-up tests and treatment within expected timescales.
- 38 The Health Board works with its Public Health Directorate, alongside Public Health Wales NHS Trust, to review screening rates, delays and differences between groups. It uses this information to identify where uptake is low and target improvement actions.
- 39 The Health Board does not make full use of this information when planning for the future. The IMTP recognises that higher screening uptake will increase demand for tests and treatment. However, there is little evidence of plans to provide the extra capacity needed. As a result, existing delays may reduce the benefits of screening programmes.
- 40 Human papillomavirus vaccination (HPV) uptake is 72% against the Welsh Government 90% target. The Health Board has plans to improve uptake through targeted action. This includes work with schools, primary care and groups with lower participation.

Cancer leadership and oversight

Cancer leadership manages current performance and risks but is less focused on longer-term service improvement and redesign

Managerial leadership

- 41 The Health Board has clear leadership for cancer services. Cancer service managers, clinicians, diagnostic teams and oncology staff oversee cancer care. They review performance, manage risks and address delays. Most of their work focuses on current services and waiting times. However, they give less attention to the changes needed to create a sustainable workforce, expand services and improve care over the longer term.
- 42 Leadership capacity varies between tumour sites. Some services do not have enough clinical leadership support. This can make it harder to improve services and manage change. As a result, joint working often focuses on current pressures and waiting times. There is less evidence of teams working together to improve services over the long term, improve patient pathways, or reduce differences in access, experience and outcomes.
- 43 Several teams manage cancer services, including cancer, diagnostic and oncology teams. As a result, services may not always work together in a consistent way to address problems that affect patient care.
- 44 The Health Board works with third sector organisations to support patient care and wellbeing. While these arrangements provide additional support for patients, there is limited evidence of the role that third sector partners play in wider cancer planning and service improvement.

Oversight and scrutiny

- 45 The Health Board has governance arrangements in place to oversee cancer services. They monitor performance and risks, but there is limited evidence that they are driving improvement. Board and committees oversee cancer performance, pathway delays, service risks and performance against national targets. This helps the Health Board to identify and escalate risks and performance concerns. However, their impact on improving services and performance is less clear.
- 46 The Board and committees do not always track whether the Health Board has delivered the agreed actions, and if so, whether the actions have resolved underlying problems. As a result, governance is stronger at identifying issues than demonstrating sustained improvement.
- 47 Attendance at the Cancer Board is mixed, which may limit its ability to drive improvement. Interviews suggest that the Cancer Board is not always used effectively to support change. Discussions tend to focus on performance targets and day-to-day pressures. There is less routine focus on patient outcomes, inequalities or the impact of improvement work.
- 48 Several governance groups and committees share responsibility for cancer services. While this provides oversight from different parts of the organisation, it can make accountability for the whole cancer pathway less clear. It can also make it harder to coordinate improvement work across services and ensure that actions are joined up.

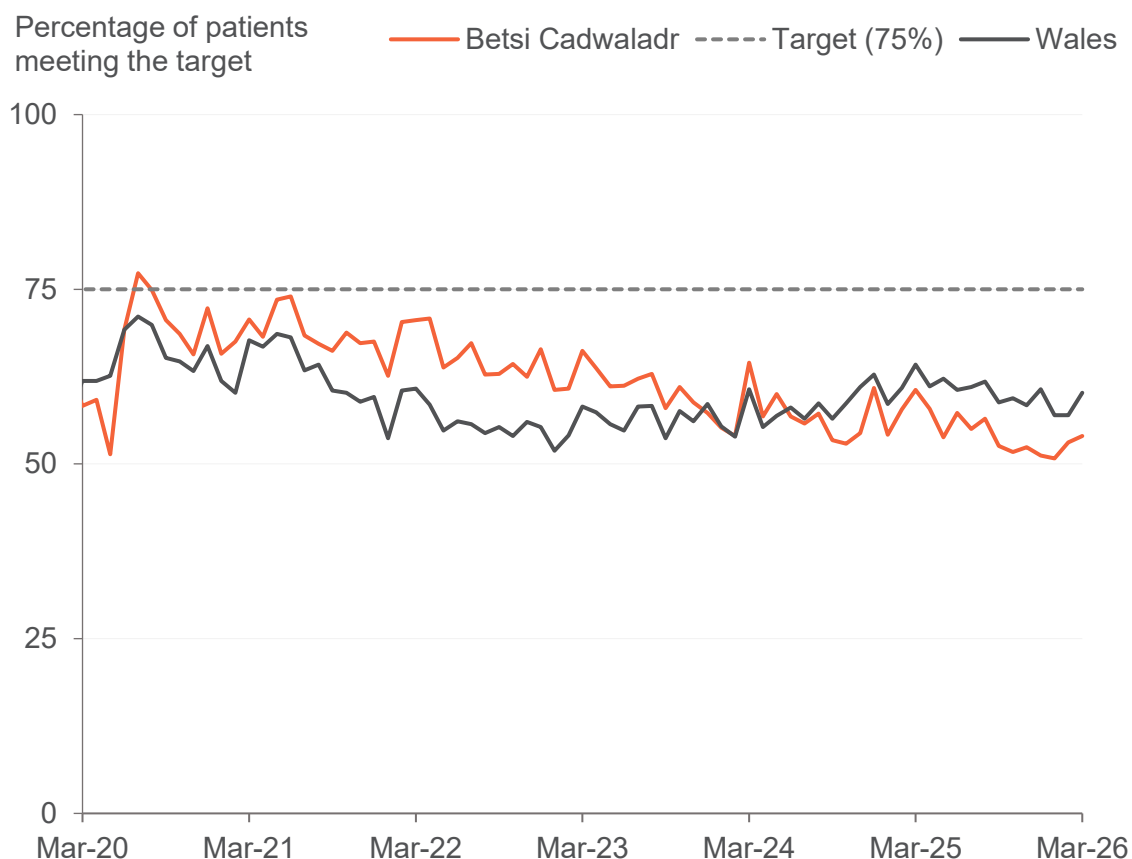
Cancer performance

Actions to improve services have not led to lasting improvements against national targets

62-day cancer performance

- 50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days of cancer first being suspected.
- 51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.
- 52 The Health Board's cancer performance is significantly below the national cancer target of 75% (**Exhibit 4**). While fluctuating, performance has shown a general deterioration over the last 4 years. This has seen the Health Board moving from one of the best performers in Wales to one of the worst.

Exhibit 4: patients meeting the 62-day cancer treatment target, Betsi Cadwaladr University Health Board, March 2020 to March 2026 (percentage)

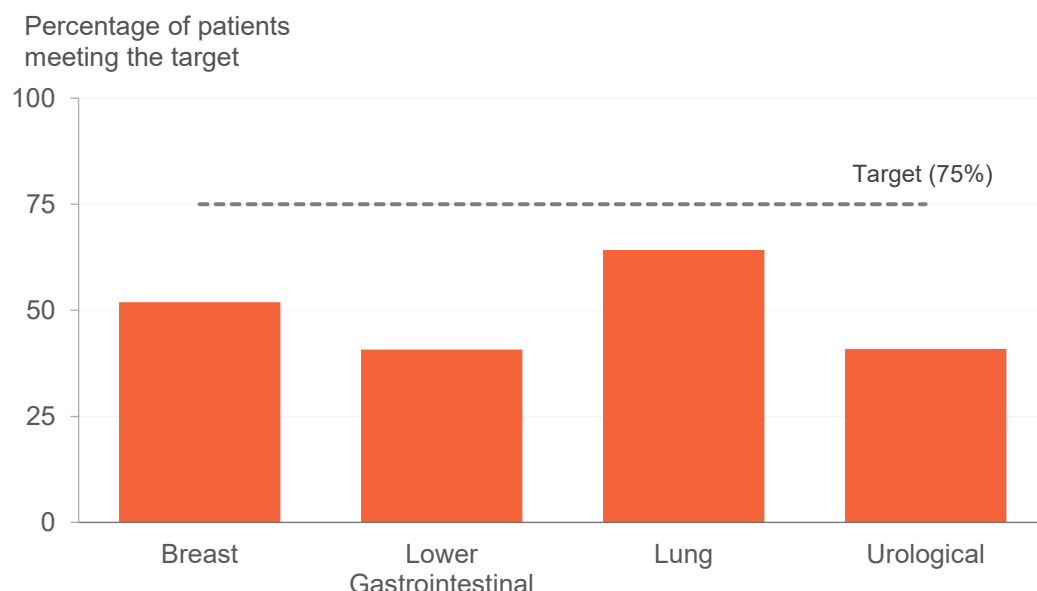


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and confirmed that they do not have cancer.

- 53 Overall performance also hides large differences between tumour types. Some services, such as skin cancer, perform better with a greater proportion of patients starting treatment within 62 days. However, performance is weaker in other areas. **Exhibit 5** shows performance across four common cancer tumour sites. It highlights very concerning lower gastrointestinal and urological and breast cancer wait performance, in particular.

Exhibit 5: patients meeting the 62-day cancer treatment target, Betsi Cadwaladr Health Board, 12-month average during 2025–26



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

1. The data shows average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

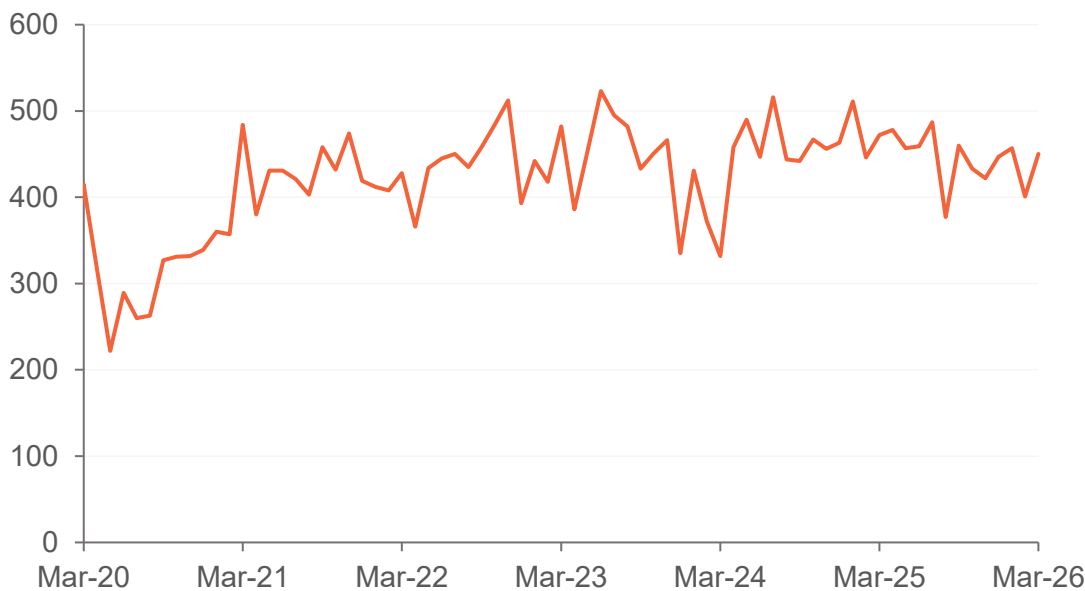
Impact of action to improve cancer services

- 54 The Health Board has taken action to reduce some of the longest waits and manage immediate service pressures. However, performance is still below national targets which is likely to result in poorer outcomes for some patients. These actions include teledermoscopy, nurse-led triage, straight-to-test pathways, and more diagnostic support. It has also bought in extra clinical support to reduce waits. These actions have reduced backlogs and improved some services, especially skin cancer services. However, performance is still below target in many areas.

- 55 The Health Board knows why performance is still below target. Demand is rising, there are not enough staff, and patients face delays waiting for tests. The Health Board is recruiting staff, using temporary workers and adding extra capacity to reduce these pressures. However, many of these actions rely on short-term funding. They help in the short term but do not address the problems causing delays.
- 56 The Health Board's actions have improved access in some areas however, overall, the pace of improvement is slow. Service treatment levels overall are not increasing (**Exhibit 6**). This is resulting in 62-day waiting list performance remaining well below the national target.

Exhibit 6: cancer patients starting treatment each month, Betsi Cadwaladr University Health Board, March 2020 to March 2026 (number)

Number of patients

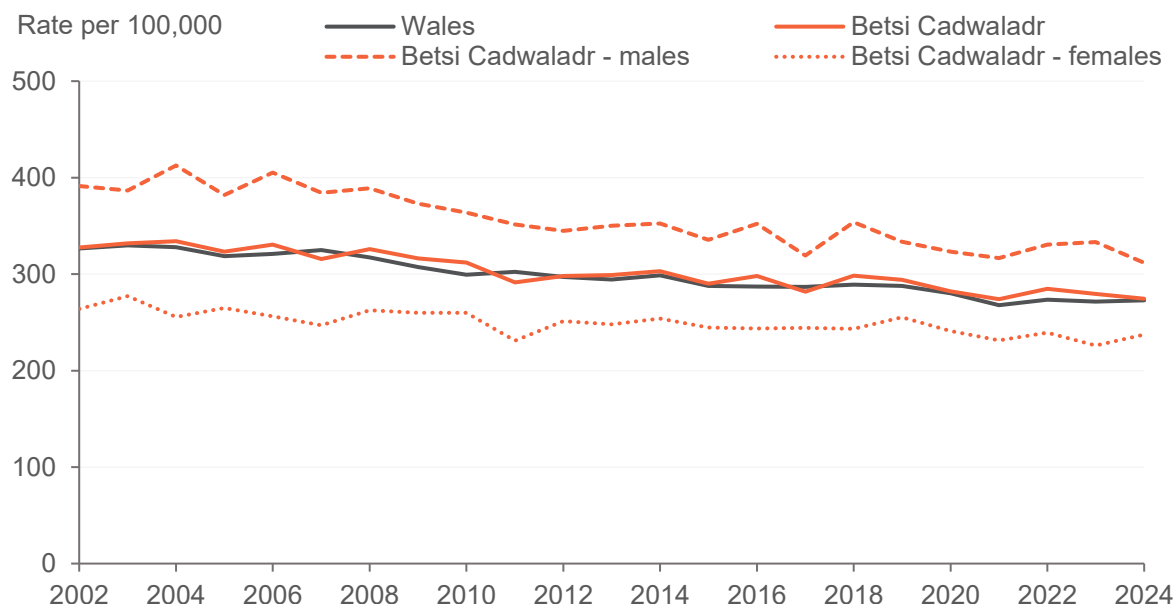


Source: Audit Wales analysis of Digital Health and Care Wales data

Improving cancer outcomes

- 57 The Health Board does not make consistent use of cancer outcomes data. There is little evidence that it uses patient feedback, survival data or stage of diagnosis data to understand whether services meet patients' needs. There is also little evidence that it uses this information to improve services.
- 58 Some services make better use of data. The prehabilitation service tracks patient fitness, complications, readmissions and length of stay. Breast cancer services also use audit results, survival data and patient feedback. Staff use this information to improve care.
- 59 Evidence also shows that findings from national audits have led to changes in some lung and colorectal cancer pathways. However, these improvement approaches are not used consistently across cancer services. While a few services are learning from outcomes, there is little evidence that the Health Board is sharing this good practice more widely across all cancer services.
- 60 Analysis of one-year cancer mortality data from 2002 to 2024 (**Exhibit 7**) shows an ongoing reduction in mortality over the past 20 years. The Health Board's rate is similar to the Wales average. Men are still more likely to die from cancer than women, although the gap is narrowing.

Exhibit 7: one-year cancer mortality, Betsi Cadwaladr University Health Board, 2002–2024 (per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

- 61 While long-term trends are improving, our national report found that cancer outcomes are still poor compared to other countries. The Health Board needs to place greater focus on outcomes data to help identify priorities and target improvement work.

Recommendations

Cancer services planning

- R1** Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions, timescales, named leads and measures of success. (**paragraph 13**)

- R2** Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (**paragraph 15**)

Cancer intelligence and data

- R3** Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board target investment where it will have the greatest impact. (**paragraph 17**)

Wider resourcing requirements

- R4** Develop enabling workforce and infrastructure plans that align the Health Board's capacity and demand analysis (see **recommendation 3**). The plans should address workforce shortages, estate and equipment constraints in the short-term. They should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future. (**paragraph 28**)

Cancer prevention and population screening

- R5** Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (**paragraph 31**)

Oversight and scrutiny

- R6** To strengthen the role of the Cancer Board, it should oversee the whole cancer pathway and be represented by all cancer services to improve care. It should make clear who is responsible for each action and regularly review progress against agreed plans and targets. (**paragraph 46**)

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience.

We have not audited the data received by the Health Board or third parties.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?
- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Health Board's cancer lead.
- Executive lead for cancer services.
- Clinical lead for cancer services.
- Director of Public Health.

We also held a focus group with the operational specialty management leads for lung, lower gastrointestinal, urological, and breast tumour sites.

2 Key terms in this report

Term	Description
62-day Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Genomic cancer therapies / genetic testing	Testing and treatments guided by tumour or inherited genetic information to better target care and risk reduction.

Term	Description
Integrated Medium-Term Plan (IMTP)	A Health Board's three-year plan setting out service, workforce, finance and delivery objectives.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

3 Management response form

This table will be completed after the report is received by Audit Committee

Recommendation	Commentary on planned actions	Completion date	Responsible officer

About us

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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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Management response form



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Audited body	Betsi Cadwaladr University Health Board
Audit name	Are cancer services improving?
Issue date	29th July 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions,	<p>The Chief Operating Officer as Executive lead will oversee the development of a single costed plan for cancer, aligned to the forthcoming National Cancer Strategy, and in line with the development of the Health Board's broader Clinical Services Plan.</p> <p>The plan will consolidate existing cancer improvement programmes into one overarching framework with clear priorities, milestones, accountable leads, resource requirements and success measures.</p>	Q2 2027-28	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	timescales, named leads and measures of success. (paragraph 13)	The plan will specifically address Single Cancer Pathway performance recovery, reduction of unwarranted variation and inequalities in access, and delivery of sustainable improvements across the cancer pathway. Annual review and refresh arrangements will be established to ensure alignment with national priorities.		
R2	Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (paragraph 15)	Each action in the above plan will be assigned to a named lead and monitored through a clear reporting schedule. Progress will be reviewed through the Cancer Partnership Board and escalated through existing corporate governance arrangements as required.	Q2 2027-28	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R3	Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board target investment where it will have the greatest impact. (paragraph 17)	<p>The Health Board will ensure cancer demand, capacity and activity forecasting is built into its existing forecasting models.</p> <p>Outputs will inform workforce planning, service redesign and investment decisions, supporting proactive management of demand and prioritisation of resources to areas of greatest need and impact.</p>	Q4 2026-27	Chief Operating Officer
R4	Develop an enabling workforce and infrastructure plan that aligns the Health Board's capacity and demand analysis (see recommendation 3). The plan should address workforce	<p>The Health Board will ensure cancer needs are included within its Workforce and Infrastructure planning informed by the demand and capacity modelling above.</p> <p>These plans will identify current and future workforce requirements, recruitment and retention priorities, succession planning</p>	Q2 2027-28	Chief Operating Officer supported by: Director of Estates and Environment and

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	<p>shortages, estate and equipment constraints in the short-term.</p> <p>It should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future.</p> <p>(paragraph 28)</p>	<p>opportunities, and training needs. They will also assess estate, diagnostic and treatment capacity constraints, identifying short-term mitigations and longer-term investment requirements to ensure services remain sustainable and responsive to future demand.</p>		<p>Director of Workforce and Organisational Development</p>
R5	<p>Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (paragraph 31)</p>	<p>The Health Board will build on existing work to develop a Cancer Prevention, Screening and Early Diagnosis Improvement Plan, working collaboratively with public health, primary care and community partners.</p> <p>The plan will focus on increasing screening uptake, improving awareness of cancer symptoms, supporting earlier diagnosis and reducing health inequalities. It will include</p>	Q2 2027-28	<p>Chief Operating Officer</p>

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		measurable objectives, targeted interventions for underserved populations and identification of sustainable funding opportunities to support delivery.		
R6	To strengthen the role of the Cancer Board, the Board should oversee the whole cancer pathway and bring services together to improve care. It should make clear who is responsible for each action and regularly review progress against agreed plans and targets. (paragraph 46)	<p>The Health Board will review the Cancer Partnership Board's terms of reference, membership and reporting arrangements to ensure the agreed structure provides oversight of the entire cancer pathway.</p> <p>Clear accountability for delivery of actions and performance outcomes will be established. This will be taken forward as part of the Foundations for the Future organisational development programme</p>	Q4 2026-27	Chief Operating Officer

Are NHS estates fit for purpose?

Betsi Cadwaladr University Health Board

August 2026



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Contents

Audit snapshot	4
Key facts and figures	7
Our findings	8
Recommendations	29
Appendices	32
1 About our work	33
2 Size and location of the Health Board's estate	36
3 Key terms in this report	37

Audit snapshot

What we looked at

- 1 Our review looked at how well Betsi Cadwaladr University Health Board (the Health Board) manages its estate.

Why this is important

- 2 The NHS estate in Wales provides the essential infrastructure to deliver healthcare services. It plays a key role in delivering safe, high-quality care and improving the patient experience. However, the NHS estate varies widely in age, condition, and location across Wales. A poorly maintained estate creates health and safety risks, including fire safety issues and potential harm to patients. An outdated estate can also affect service performance, be less energy efficient, and be a barrier to providing modern healthcare.
- 3 The NHS in Wales needs to modernise its estate, deliver environmental improvements, improve access, and adapt to meet the needs of modern healthcare. There are several NHS strategies and plans which are dependent on estate improvements. These range from immediate strategic priorities relating to infrastructure and capital investment, to the requirements to reduce carbon emissions and improve energy efficiency.
- 4 Welsh Government's 2018 long-term plan for health and social care – [A Healthier Wales](#) – highlighted the importance of the NHS estate as a key enabler for transforming health and social care. Including the need for modern facilities, supporting digital integration, and a focus on energy efficiency and environmentally friendly practices. This is all against a backdrop of significant financial pressures across the NHS in Wales.

What we have found

- 5 The Health Board's estates strategy needs updating. It lacks clear milestones, routine monitoring and a funded delivery plan. Governance arrangements are in place, but Board and committee oversight is limited. Operational arrangements are fragmented across the three Integrated Health Communities. This creates duplication and limits a consistent approach to performance, compliance and risk.
- 6 The Health Board has processes in place to manage capital investment. However, short-term planning, weak strategic alignment and poor management information reduce assurance that funding is directed to the highest priorities. The estate has significant backlog risks. Despite being newer than the all-Wales average, it has high maintenance costs. Incomplete asset data and paper-based systems also limit effective decision-making.
- 7 The Health Board faces safety and compliance risks from the condition of its estate, particularly fire safety. Compliance has improved, but key measures are still below the all-Wales average. Fragmented oversight, weak action tracking and limited use of staff and patient feedback make risks harder to manage. The estates workforce also faces vacancies, recruitment challenges, sickness absence and ageing workforce risks. Limited workforce planning creates risks to long-term sustainability.

What we recommend

- 8 We have made nine recommendations to the Health Board which focus on:
 - refreshing the estates strategy;
 - reporting the delivery of the strategy;
 - strengthening Board oversight of estates;
 - streamlining operational estates arrangements across the three Integrated Health Communities;
 - strengthening the management of estates risk;

- improving estates data;
- developing a plan to address backlog maintenance, compliance and high-risk fire safety actions;
- developing a rationalisation and disposal strategy; and
- developing and implementing a clear estates workforce plan.

Key facts and figures

278

Number of properties owned by the Health Board in 2024-25.

**£33.7
million**

Capital monies available to manage estates in 2025-26 (excluding end-year funding).

**£278
million**

Cost to eradicate risk-adjusted backlog in 2024-25, an increase of 8.27% since 2022-23. High-risk backlog accounts for £109 million.

21.1%

Percentage of the 3978 issues addressed following fire safety assessments in 2024 at the end of September 2025.

128

Number of estates related clinical incidents in 2024-25.

6.7%

Vacancy rate in estates at the end of March 2025, compared to an all-Wales position of 11.6%.

6.4%

Sickness Absence rate at the end of March 2025, compared to an all-Wales position of 6.6%.

Our findings

Strategic approach to estates

The Health Board has an estates strategy, but it lacks milestones, monitoring, an affordable financial plan, and alignment with key strategies

- 9 The Board approved its estates strategy in January 2023. It covers the period 2023 to 2033. We reviewed the strategy and found that it sets out a broad framework for the future estate. However, it does not include clear milestones, timescales, or a delivery plan.
- 10 In May 2025, the Performance, Finance, and Information Governance Committee reviewed estate rationalisation. It found the estates strategy too generic and asked for the team to refresh the strategy.
- 11 At the time of our audit, this work had not started. The Health Board was waiting for the detail of the clinical services plan, due in autumn 2026 as part of the Foundations for the Future programme. This plan will help identify future estate needs.
- 12 Positively, the estates strategy:
 - covers all estates within the Health Board's responsibility, including primary and community care;
 - reflects the Health Board's duties under the Equality Act and the socio-economic duty; although it provides little detail on this.
 - identifies opportunities to work with regional partners, although it provides little detail on how this will happen.

13 However, the strategy:

- is not supported by reliable estates data;
- does not include clear milestones, targets, or performance measures;
- is not aligned to the Health Board's long-term strategy, as the Health Board does not yet have one;
- is not aligned to key enabling strategies, including its clinical services, workforce, and digital strategies;
- does not clearly show how it supports national priorities, including A Healthier Wales, the Well-being of Future Generations Act and national clinical frameworks;
- does not adequately reflect commitments to environmental sustainability, energy efficiency, and biodiversity; and
- is not supported by an affordable financial plan.

14 The strategy refers to engagement with staff and patient groups. However, it does not identify engagement with community partners.

Governance arrangements for managing estates

The Health Board has estates risk and accountability processes in place. However, fragmented governance, weak oversight and unclear responsibilities reduce assurance and weaken risk management

Lines of accountability

- 15 The Health Board has formally defined executive accountability for estates. Overall responsibility sits with the Chief Executive, who delegates responsibility to the Director of Environment and Estates.
- 16 Formal accountability for estates is clear, but there is confusion at operational level. Some staff incorrectly name the Executive Director of Finance as the executive lead. This weakens clarity about who leads estates in practice.

Corporate oversight of estates

- 17 There is limited Board and committee oversight of estates.
- 18 The Board receives few formal estates updates. These are limited to capital disposals, the annual fire safety report, and updates through the corporate risk register.
- 19 The Planning, Population Health and Partnerships Committee oversees estates at Board level. Its remit includes capital and estates strategies. The Director of Environment and Estates attends the committee. However, oversight is not consistent. The committee mainly considers estates through wider planning reports. As a result, scrutiny is periodic and high level.

- 20 The committee relies on strategy papers and embedded updates. It does not routinely monitor estates risks, compliance or delivery. The committee has not received an update on delivery of the estates strategy since January 2023. The Performance, Finance and Information Governance Committee received an update in June 2025, but this committee is not responsible for overseeing progress. As a result, the assuring committee has limited assurance that the strategy is being delivered effectively.
- 21 The Performance, Finance and Information Governance Committee supports scrutiny of estates delivery and financial performance through its review of capital monitoring reports and the corporate risk register. However, the committee does not receive standalone reports on wider estates performance or operational estates issues.
- 22 The Health Board holds information on backlog maintenance and related safety risks. However, it does not routinely report this information to the Board or committees. Reports do not consistently describe or quantify these risks. This makes it harder to understand the impact on patient safety, staff safety and service delivery.

Operational management

- 23 The Director of Environment and Estates has overall responsibility for operational estates services. The Head of Operational Estates leads day-to-day operational management. Three Estates Operations Managers support this role across the East, Central and West Integrated Health Communities (IHCs). Each area has local estates teams that deliver maintenance, compliance and infrastructure services.
- 24 This structure supports local delivery, maintenance, and compliance work. However, it does not offer a clear corporate view of estates activity. Each IHC has separate estates teams and safety groups. These groups oversee areas such as fire, water, and asbestos.
- 25 No single estates group brings this activity together across the Health Board. Groups identify actions, but action tracking is not consistent. This limits assurance that issues are recorded, monitored and closed on time.

- 26 Current arrangements focus too much on local IHC activity. They do not support estate decisions across the Health Board as a whole. This limits strategic oversight of estate priorities, risks and performance. It also weakens operational control and Board assurance.
- 27 The arrangements also lack wider organisational input. Workforce, finance, and digital teams have limited involvement. As a result, estates discussions do not consistently consider impacts on performance, quality, safety, and finance.
- 28 The Health Board also does not use benchmarking data systematically. This limits its ability to compare performance and inform estate decisions.

Managing estate risks

- 29 The Health Board manages estates risks through several levels of its risk management framework. This includes the Board Assurance Framework (BAF), the Corporate Risk Register (CRR), an operational estates risk register, and local risk management arrangements across the three IHCs.
- 30 The BAF identifies strategic risks that could affect the Health Board's ability to deliver service transformation and infrastructure investment. However, it does not explicitly recognise estate condition, backlog maintenance, or wider infrastructure deterioration as strategic risks. This reduces visibility of the potential impact these issues could have on patient safety, service delivery, and organisational resilience.
- 31 The Health Board manages estates risks through its CRR. Estates-related issues are captured under the 'Safe Environment' risk, which links to the BAF. The register sets out key controls, mitigating actions, accountable leads, and target dates. However, the level of assurance is still moderate, and the risk score has not reduced significantly. This suggests that the actions taken have not yet substantially reduced the underlying risk.

- 32 The Health Board oversees corporate estates risks through its governance framework, including the Performance, Finance and Information Governance Committee. However, accountability and reporting are fragmented across several committees and groups. This makes it difficult to get a single comprehensive view of estates risks and progress against mitigating actions.
- 33 The Health Board keeps an operational estates risk register covering infrastructure, compliance, and business continuity risks across its estate. This register offers an organisation-wide view of operational estates risks and supports operational management.
- 34 At a local level, the three IHCs identify and manage estates risks through local risk registers, spreadsheets and systems such as DATIX. These risks are reviewed through local governance arrangements. They also inform operational decision-making and funding priorities. However, some risks were duplicated, outdated or recorded as actions rather than clearly defined risks.
- 35 The Health Board also manages estates risks through a range of discipline specific safety groups covering areas such as fire, water, asbestos and electrical safety. Evidence from focus groups shows that issues can be escalated through operational health and safety structures into wider Health Board governance arrangements.
- 36 The Health Board has established multiple mechanisms to identify and escalate estates risks. However, the links between strategic, corporate and operational risk management are not always clear. There is no single forum with oversight of estates risks across all three IHCs. This creates fragmented arrangements, duplicated scrutiny and inconsistent oversight of actions and risk reduction.

Using financial resources to improve estates

The Health Board has established capital funding arrangements. However, short-term planning, governance weaknesses and limited strategic alignment reduce assurance over estate investment

Funding prioritisation process

- 37 The Health Board has a suitable approach to how it prioritises the capital funds available to improve its estate.
- 38 In 2025-26, the Health Board had £15.2 million available from discretionary capital and dedicated estates funding. This investment has increased over the last three financial years (Exhibit 1).

Exhibit 1: use of discretionary funding and dedicated funds for estates for 2023-24, 2024-25 and 2025-26 (£ million)

Fund	2023-24	2024-25	2025-26
Discretionary capital allocation	7.3	7.2	6.6
Estates and Facilities Advisory Board (EFAB) funding	4.3	3.8	-
Targeted Estates Fund (TEF)	-	-	8.6
TOTAL	11.6	11.0	15.2

Source: Audit Wales analysis of financial monthly monitoring returns

Note: TEF is a Welsh Government capital fund that targets high priority estate risks in the NHS, including safety, compliance, and resilience. It replaced the Estates and Facilities Advisory Board (EFAB) funding in 2025-26.

- 39 In 2025-26, the Health Board also received £18.5 million of all-Wales capital funding for estates. This was in addition to its Targeted Estates Fund allocation. The funding supported the development of the Regional Orthopaedic Hub in Llandudno and upgrades to the electrical infrastructure at Ysbyty Glan Clwyd.
- 40 In total, the Health Board received £33.7 million of capital funding for its estate. This falls well short of the estimated £278 million needed to address risk-adjusted backlog maintenance. It is also well below the £239 million needed to achieve physical condition B across the estate. This shows the significant gap between available funding and estate need.
- 41 The Health Board has also used other funding sources to support estate improvements, including £40,303 from charitable funds, and funding through the Regional Partnership Board. Regional funding has supported schemes including the Caledfryn, Denbigh Health and Well-Being Hubs. Progress of which is monitored through the Strategic Planning and Service Change Group.
- 42 The Health Board has arrangements to oversee capital investment and prioritise funding. The Capital Programme Management Team develops the capital programme and allocates funding. The management group includes representatives from estates, finance, procurement and digital services. The Interim Executive Director of Transformation and Strategic Planning chairs the group. This supports consideration of affordability, deliverability and infrastructure needs. However, at the time of our audit, the group's terms of reference were outdated and under review, having last been updated in 2015.
- 43 The Capital Investment Group scrutinises capital investment proposals. It also considers whether they align with organisational and service objectives. For estates projects, the group reviews business cases and recommends schemes for inclusion in the capital programme and the Integrated Medium-Term Plan.

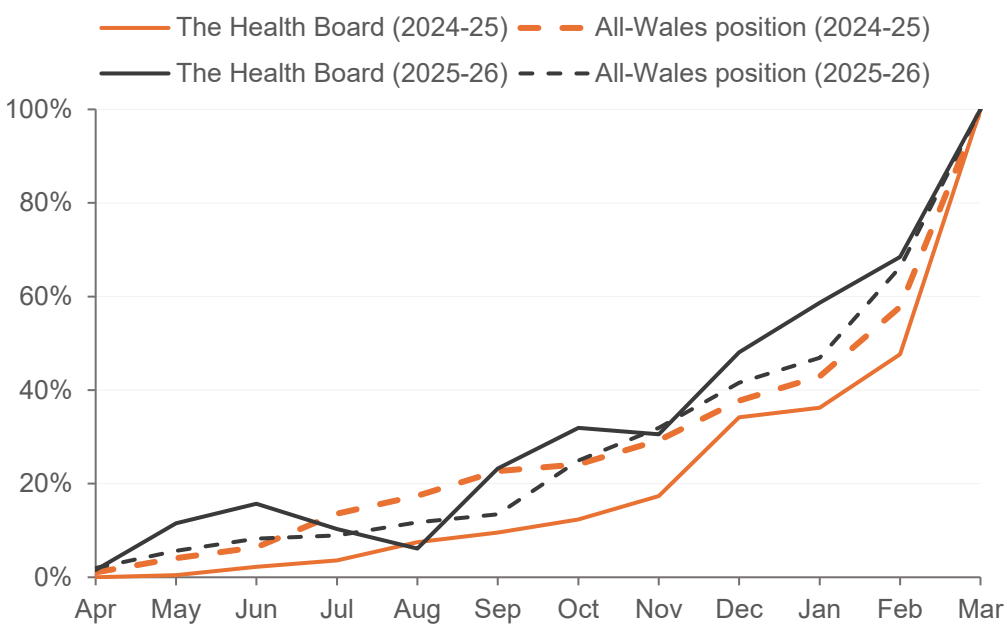
- 44 In April 2025, Internal Audit reviewed discretionary capital funding arrangements and found that governance and monitoring arrangements were reasonable. However, it also found weaknesses in how the Health Board records and explains prioritisation decisions. Some documents were out of date, and approval processes were inconsistent. These weaknesses make it harder to show that funding decisions are based on organisational priorities and risk.
- 45 The Health Board has a two-year capital programme to support short-term planning. It allows schemes to progress when funding becomes available. However, the short timeframe and frequent changes reduce the programmes value as a strategic planning tool. This weakens assurance that investment decisions align with longer-term estate needs.
- 46 The Health Board does not have a clinically informed estates strategy. This weakens the link between estate need and capital investment. Priority schemes come from annual bids from divisions and service leads. They are not based on a clear assessment of risk, service need and organisational priorities. As a result, the Health Board cannot show that it directs funding to its highest-priority estate risks and long-term infrastructure needs.

Monitoring and managing capital spend

- 47 The Health Board has arrangements to monitor and control capital spending. These arrangements support effective financial management, although the Health Board is not making maximum use of its discretionary estates funding.
- 48 The Health Board monitors capital expenditure, project progress and financial pressures through the Capital Programme Management Team. It receives regular reports on scheme performance, expenditure and risks. This gives the Health Board programme-level oversight of capital spending.

49 We reviewed spending against the Health Board’s discretionary allocation for estates for 2024-25 and 2025-26. In both years, it spent less than its allocation (15% in 2024-25, and 12% in 2025-26). Spending was also concentrated towards the end of the financial year. This may reflect reactive budget management as projects progress and funding becomes available (Exhibit 2).

Exhibit 2: monthly running total discretionary estate spend, compared with the all-Wales position, for 2024-25 and 2025-26 (percentage of total spend)



Source: Audit Wales analysis of financial monthly monitoring returns

50 The Health Board has processes for managing programme slippage. It reallocates funding to make best use of available resources and reduce underspend. However, it does not have a clear, prioritised reserve list of schemes. This reduces transparency and makes it harder to show that funding goes to the highest-priority needs.

- 51 The Performance, Finance and Information Governance Committee receives regular reports on capital spending and programme delivery, within the finance report. However, weaknesses in the wider governance framework may limit scrutiny and assurance.

Ensuring an efficient and productive estate

The Health Board’s estate is under significant condition pressures, while weak management information and maintenance backlogs constrain performance and efficiency

Condition of the estate

- 52 The Health Board’s estate faces significant condition and maintenance pressures.
- 53 Compared with the all-Wales position, the Health Board has a newer estate. A lower proportion of its buildings were built before 1948, and a lower proportion of its estate predates 1995. However, the Health Board faces higher maintenance costs than the all-Wales average. The cost to remove high-risk backlog per square metre is the highest in Wales. It has also increased since 2023-24. The cost of achieving physical condition B is also higher than the all-Wales average (Exhibit 3).

Exhibit 3: age and condition of the estate, compared to the all-Wales position, 2024-25

Measure	The Health Board	All-Wales position
% of estate built before 1948	12.8	13.5
% of estate built before 1995	53.2	63.9
Cost to removed high-risk backlog per m ² occupied floor area (£)	297.06	164.60

Measure	The Health Board	All-Wales position
Cost to remove high and significant-risk backlog per m ² occupied floor area (£)	733.04	458.43
% of estate meeting physical condition standard B	81	83
Cost to reach physical condition B per m ² occupied floor area (£)	651.55	538.54

Source: Estates and Facilities Performance Management System (EFPMS)

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

- 54 Across the Health Board's sites, the cost to remove high-risk backlog is highest at Bryn-y-Neuadd Hospital, at £1,115 per m² of occupied floor area. Royal Alexandra Hospital has the highest cost to reach physical condition B, at £1,720 per m². Across the main hospital sites, Ysbyty Gwynedd has the highest cost to remove high-risk backlog and reach physical condition B, at £741 and £1,621 per m² respectively.
- 55 The Health Board has not commissioned an external estates condition survey in the past three years. This limits independent assurance on the condition of its estate. It also relies on a remaining useful life assessment from 2009. Although the Health Board is discussing a future survey, it has not confirmed funding or a delivery timetable. Relying on internal surveys may reduce the consistency of data used to assess risk and set capital priorities.
- 56 Condition survey data becomes less reliable over time. Since 2009, the Health Board's estate has changed because of ageing buildings, new compliance requirements, and changing service needs. This increases the risk that decisions are based on information that no longer reflects the current estate.

- 57 The Health Board reports that two sites include buildings with Reinforced Autoclaved Aerated Concrete (RAAC). These are Bryn-y-Neuadd Hospital and Wrexham Maelor Hospital. It did not report the associated costs.
- 58 The Health Board has an up-to-date Planned Preventative Maintenance (PPM) schedule. Data supplied by the Health Board shows that some planned maintenance is taking place. However, spending on reactive maintenance is much higher. This shows a continued reliance on reactive work, which increases risk and reduces value for money.

Robust management information

- 59 The Health Board is not making effective use of management information to support strategic management of its estate.
- 60 The Health Board keeps an asset register within its GRAMMS (General Repairs and Maintenance Management System) information system. The Health Board uses GRAMMS to schedule maintenance. However, it has limited assurance that the asset information held in GRAMMS is complete or up to date. The Health Board still relies heavily on paper-based estates management processes. It does not have a fully digital computer-aided facilities management system for helpdesk and maintenance work. As a result, managers cannot easily access timely and reliable information.
- 61 The Health Board plans to introduce a CAFM (Computer Aided Facilities Management) system. However, it has not yet secured funding, and it still needs organisational approval. The Health Board's information on estate utilisation is inconsistent and fragmented. Some areas assess space use, but there is no organisation-wide approach to collecting, analysing, or reporting this data. This limits the Health Board's ability to identify underused space and make informed decisions about rationalisation.
- 62 Several committees and governance groups oversee estate performance. These groups focus more on capital investment and risk than on performance, productivity and workforce issues. As a result, the Board does not have a clear, joined-up view of how well the estate is managed or how it could be improved.

Maximising productivity and efficiency

- 63 The Health Board is taking limited action to improve productivity and efficiency.
- 64 Compared with the all-Wales position, the Health Board performs less well on functional suitability and energy performance. It performs better on reported space utilisation. However, limited assurance over space utilisation data means this comparison should be treated with caution (Exhibit 4).

Exhibit 4: productivity and efficiency performance of the estate, compared to the all-Wales position, 2024-25

Measure	The Health Board	All-Wales position
% of estate functionally suitable	80	84
% of space utilisation	95	92
energy performance (kilowatts (kw))	384	367

Source: Estates and Facilities Performance Management System

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

- 65 Across the Health Board’s sites, Bryn-y-Neuadd Hospital has the highest proportion of space that is not functionally suitable, at 70%. It also has the greatest level of underutilised space, at 60%. By comparison, 52% of the estate at Abergele Hospital is not functionally suitable.
- 66 The Health Board does not have a formal estates disposal strategy. It is developing work on estate rationalisation, but this is still in draft. It is not yet part of a clear strategic framework.

- 67 Without a clear approach to disposals, the Health Board may miss opportunities to release capital and reinvest it in higher-priority schemes. This makes capital prioritisation more reactive and limits assurance that investment decisions are optimised across the estate. The Health Board has not reported any covenants that affect how it can use its buildings.
- 68 The Health Board has made some targeted estate improvements. These include energy-efficiency measures such as light emitting diode (LED) lighting and boiler replacement.
- 69 However, a lower proportion of the Health Board's space has LED lighting than the all-Wales position. The proportion is 22.9%, compared with 45.4% across Wales. Positively, the Health Board has no gas boilers over 10 years old. It is the only NHS organisation in Wales in this position.
- 70 Broader progress in improving utilisation, functional suitability and operational efficiency is limited. The Health Board has not yet fully realised opportunities to optimise space through leasing or rationalisation. It also makes limited use of technology to improve efficiency. As a result, the estate continues to constrain service delivery and organisational efficiency.

Supporting the quality of care

Weak oversight of estates safety risks and ongoing compliance challenges limit assurance that the estate supports safe and effective care

Minimising risk to patient care

- 71 The Health Board has weak arrangements for managing and reducing safety risks arising from the condition of its estate. These risks affect both patients and staff.
- 72 The Health Board reviews estates safety risks and incidents through several operational groups and reports. However, oversight is fragmented. There is no single reporting route that brings together incidents, risks, compliance issues and actions at a corporate or operational level. This limits assurance that estates safety concerns are identified, escalated and addressed consistently. It also limits learning across the organisation.
- 73 Incident data shows a year-on-year increase since 2022. Reported incidents rose from 41 in 2022-23 to 128 in 2024-25, but the data does not explain why this has happened. The increase may reflect worsening estate conditions, better reporting, improved staff awareness, or a mix of these factors.
- 74 Estate-related safety risks do not feature explicitly in the Quality, Safety and Experience Committee's work programme. The committee relies on indirect reporting through corporate risk and quality reports. This reduces visibility of infrastructure-related safety risks and limits dedicated scrutiny and challenge.
- 75 The Health Board does not systematically capture, analyse or report staff and patient feedback about estate condition. This limits its understanding of how estate issues affect service delivery, patient experience and staff wellbeing. It also weakens the evidence used to prioritise investment and improvement.

76 Without structured feedback, the Health Board has limited assurance that user experience informs decision-making or helps improve the estate. This weakens its ability to show that it responds to concerns raised by staff and patients.

Ensuring compliance

77 The Health Board has weaknesses in the way it manages statutory and safety compliance across its estate.

78 The Health Board has improved its statutory compliance performance in recent years. However, it is still below the all-Wales average for key measures, including statutory health and safety and fire safety compliance (Exhibit 5).

Exhibit 5: occupied floor space meeting statutory and safety requirements, compared to the all-Wales position, 2024-25 (percentage)

Measure	The Health Board	All-Wales position
% of occupied floor space meeting statutory health and safety requirements	82	87
% of occupied floor space meeting statutory fire safety requirements	76	84

Source: Estates and Facilities Performance Management System

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

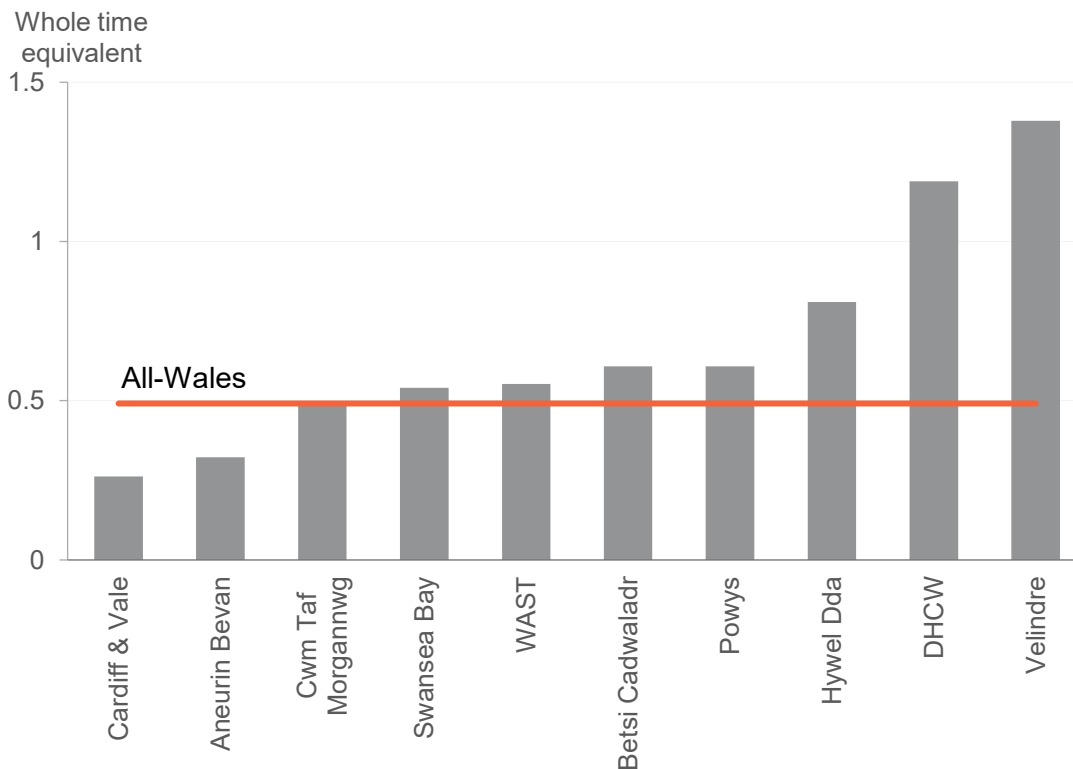
- 79 Abergele Hospital has the lowest level of occupied floor space meeting statutory health and safety requirements, at just 15%. It is one of only three hospitals in Wales, and the only site across the Health Board's estate, below 50%. Fire safety compliance is also low at Abergele Hospital at 50%. Royal Alexandra Hospital and Ysbyty Gwynedd Hospital have the second lowest level of compliance across the Health Board at 60%.
- 80 The Health Board reports that 90% of required fire risk assessments are complete. However, further work is needed to improve fire safety management and reduce risk.
- 81 In 2024-25, there were 3,138 outstanding actions from fire risk assessments. The Health Board reports that it lacks capacity and resources to manage this volume of actions. This reduces assurance that it is managing fire risks effectively.
- 82 The Health Board has no formal fire enforcement notices. However, it has received four informal notices from the fire service since 2025. These relate to fire alarm systems, fire doors, and electrical testing. Although they are not formal enforcement notices, they show gaps in fire safety controls or delays in resolving issues.
- 83 The Health Board has a water safety policy and carries out regular risk assessments. In 2024-25, it completed 278 of 365 required assessments. It also addressed 79% of identified issues, or 1,815 of 2,311. This shows ongoing action to manage water safety risks. However, incomplete assessments and remedial actions limit assurance that the Health Board controls these risks across the estate.
- 84 The Health Board targets funding towards statutory compliance risks and has secured additional resources. However, it is unclear whether available funding is enough to address backlog maintenance and compliance risks across the estate.
- 85 The Health Board monitors compliance across its estate and has improved performance in some areas. However, poor data quality, weak asset information and limited system integration make it harder to identify, report and manage risks consistently.

Managing the estate workforce

The estates workforce faces vacancies, sickness absence, and ageing workforce risks. These limit capacity, increase costs, and affect sustainability

86 The Health Board has a slightly larger estates team than the all-Wales average. At the end of March 2025, it had 0.61 whole-time equivalent staff per 1,000 m² of occupied floor area. This compares with the all-Wales average of 0.49 (**Exhibit 6**).

Exhibit 6: size of the estates function per 1,000 m² occupied floor space, by NHS body on 31 March 2025 (whole time equivalent)



Source: Audit Wales analysis of NHS data

- 87 The Health Board reports a moderate vacancy level in its estates team. At the end of March 2025, the vacancy rate was 6.7%, or 16.4 whole-time equivalent staff. This was below the all-Wales rate of 11.6%. Vacancies reduced to 14.74 whole-time equivalent staff by September 2025. Recruitment restrictions have limited the Health Board's ability to fill posts. Recruiting skilled estates staff is also difficult because the Health Board cannot always match private sector pay rates.
- 88 The Welsh Government required NHS bodies to stop using agency staff in estates by 30 September 2025. The Health Board met this target.
- 89 The Health Board uses external contractors to support its in-house workforce. At the time of our review, it used third-party providers for key statutory compliance services. These included water safety, electrical safety, fire safety and asbestos management. In 2025-26, the total annual spend on these services was £93,530.
- 90 At the end of September 2025, the Health Board reported a sickness absence rate of 6.4%. This is just below the all-Wales average of 6.6%, but places further pressure on capacity.
- 91 The Health Board does not have a clear workforce plan for its estates function. At the end of March 2025, 24.9% of estates staff were aged over 60. This was slightly below the all-Wales average of 25.4%. Positively, the Health Board is using apprenticeships to build future capacity. It had two apprentices in post and one vacancy at that time.
- 92 The Health Board has not explored whether partnership working could help address current and future estates workforce challenges.
- 93 The Health Board monitors training compliance for estates staff. In March 2025, compliance with statutory and mandatory training was 92%, against a target of 85%. The main gaps were in information governance, fire safety and moving and handling.

Recommendations

94 We have made nine recommendations because of our work.

R1 The Health Board should refresh the estates strategy once it has developed its clinical plan, ensuring the estate supports the delivery of that plan. The refreshed strategy should be based on robust data and include clear delivery milestones, performance measures, and funding assumptions (**paragraphs 11-13**).

R2 The Health Board should set up routine reporting to the Board and relevant committees on delivery of the refreshed estates strategy. Reporting should cover progress, risks, benefits, affordability and alignment with the clinical plan (**paragraph 21**).

R3 The Health Board should review its estates governance and reporting arrangements to clarify accountability and improve oversight of estate condition, backlog maintenance, statutory compliance, performance, priorities and risks (**paragraphs 17-23**).

R4 The Health Board should streamline estates governance across the three Integrated Health Communities. This should reduce duplication, improve action tracking, and create a single forum to oversee operational estates risks, compliance and performance **(paragraphs 24-28)**.

R5 The Health Board should strengthen estates risk management by linking local, operational, corporate and strategic risks. It should clarify ownership, remove duplication, improve action tracking and report whether mitigating actions are reducing risk **(paragraphs 31-37)**.

R6 The Health Board should develop an approved plan and business case for a digital estates management system. The plan should improve asset, condition, utilisation, compliance, incident, feedback and performance data **(paragraph 62)**.

R7 The Health Board should develop a long-term plan to address backlog maintenance, improve estate condition and strengthen statutory compliance. The plan should prioritise high-risk issues, including outstanding fire safety actions, and identify funding options **(paragraphs 54-57 and 82-86)**.

R8 The Health Board should develop an estate rationalisation and disposal strategy. This should show underutilised or unsuitable space, support service planning, release capital where appropriate, and direct investment towards the highest-priority estate risks **(paragraph 67-68).**

R9 The Health Board should develop a comprehensive estate workforce plan. It should cover capacity, succession planning, recruitment, sickness absence, agency reduction, partnership opportunities, digital skills and future workforce requirements **(paragraph 92-93).**

Appendices

1 About our work

Scope of the audit

We looked at the following areas during the period February to May 2026:

- strategic planning;
- governance arrangements;
- utilisation of financial resources;
- estate productivity and efficiency;
- implications on quality and safety; and
- workforce management.

We did not look at:

- major estates projects funded (or potentially funded) through the All-Wales Capital Health Programme;
- operational management of estates, including the management of leased estate;
- 'soft facilities management' services such as cleaning or security services, which are also key to supporting fit-for-purpose estate; and
- primary care estates.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the NHS body have a clear planning approach for its estate in the medium to longer term?

- Does the NHS body have effective governance arrangements for estates management?
- Is the NHS body utilising its financial resources available for estates appropriately?
- Does the NHS body have an efficient and productive estate?
- Does the NHS estate support the quality of care and experience of patients and staff?
- Does the NHS body have effective arrangements for managing its estate workforce?

Criteria

We assessed the Health Board's approach against audit criteria shaped by:

- NHS Wales planning frameworks, and other relevant NHS Wales planning documents, including the NHS Wales Decarbonisation Strategic Delivery Plan 2021-30;
- Legislation, including the Wellbeing of Future Generations Act (2015), the Equality Act 2010 and the Public Sector Equality Duty (PSED);
- Relevant guidance from NHS Shared Services Partnership;
- Previous audit work on the management of NHS estates.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Performance, Finance and Information Governance Committee and Capital Programme Management Team terms of reference.
- Key strategies and plans, including the Annual Plan, the Estates Strategy, and Capital Programme.

- Key risk management documents including the strategic and operational risk registers.
- Relevant operational committee minutes and agendas including the Capital Investment Group.

We interviewed the following key stakeholders:

- Director of Environment and Estates
- Head of Operational Estates
- Head of Capital

We also held two focus groups with:

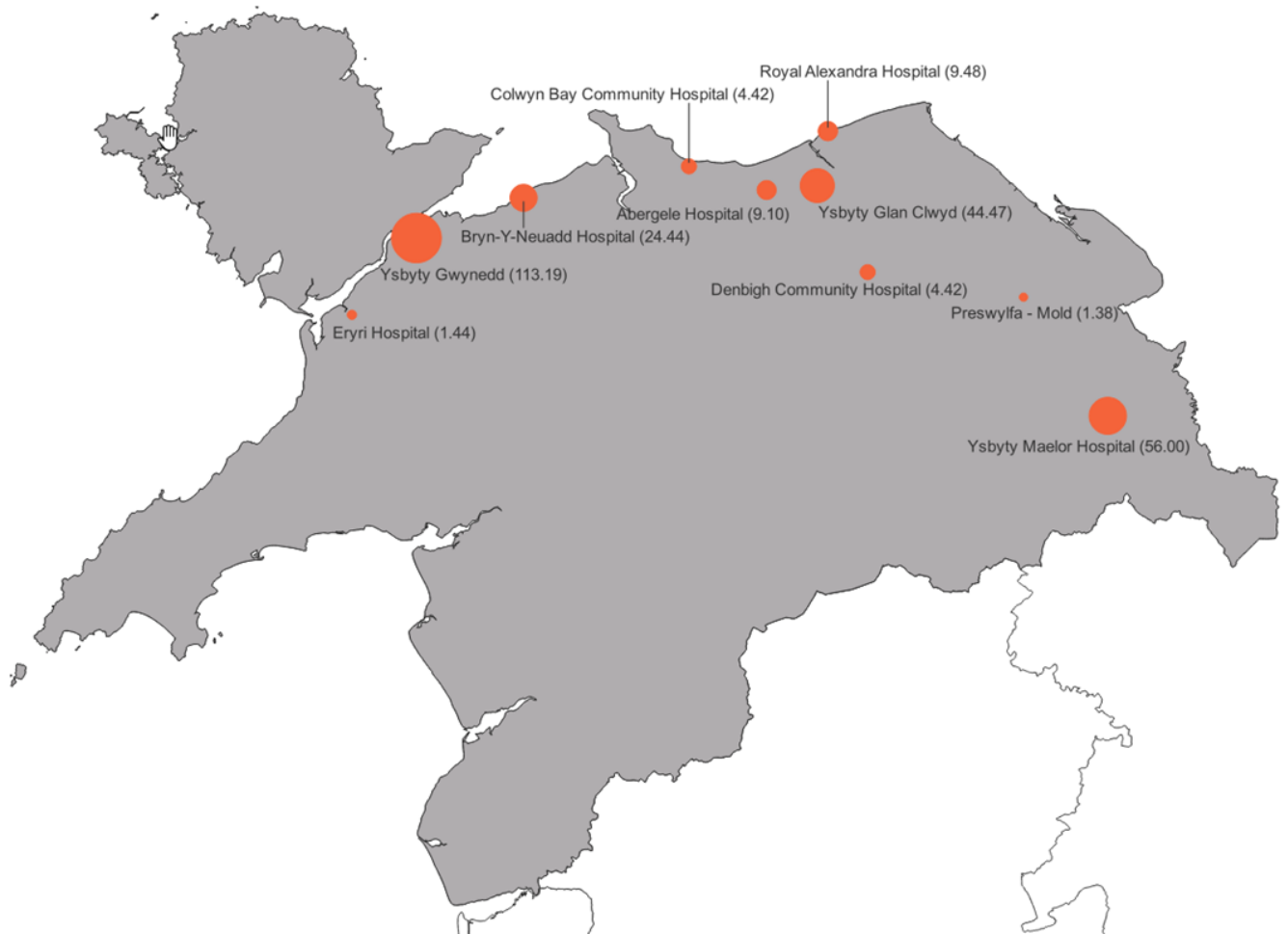
- the Integrated Health Communities Directors for East, West and Central
- the Fire Safety Lead, Health and Safety Lead, Asbestos Lead and Electrical Safety Lead.

We reviewed national data available from the Estates and Facilities Performance Management System (EFPMS), monthly financial monitoring returns submitted to Welsh Government, and local data provided to us by the Health Board. We have not audited the data from these sources.

2 Size and location of the Health Board's estate

The map below shows the size and location of the Health Board's risk adjusted backlog in 2024-25. It excludes sites with a backlog of £1 million or less.

Exhibit 7: size and location of the Health Board's risk adjusted backlog, 2024-25 (£ million)



Source: Estates and Facilities Performance Management System (EFPMS)

3 Key terms in this report

Term	Description
2018 Estatecode Wales	Gives detailed advice on how to manage land and buildings used for healthcare services.
Backlog maintenance	A measure of the investment needed to restore a building to a set standard, based on assessed risk.
Computer Aided Facilities Management (CAFM)	A system used to manage estates and facilities work, including asset records, planned and reactive maintenance, compliance checks, and reporting.
DATIX	An electronic system used across NHS Wales to record, manage and analyse patient safety incidents, concerns, complaints, and risks.
Discretionary capital	Funds that an organisation can allocate at its own discretion.
Estates and Facilities Advisory Board (EFAB)	A Welsh Government capital funding programme that supported targeted estates improvements across NHS Wales, including infrastructure, decarbonisation, and fire safety. It was replaced by the Targeted Estate Fund (TEF) in 2025-26.
Estates and Facilities Performance Management System (EFPMS)	An all-Wales system used to collect and report data on NHS estates and facilities. It supports monitoring, benchmarking, and improving performance, and informs planning and decision-making.
Functionally suitable	The percentage of occupied floor area that meets the <u>2018 Estatecode Wales</u> Condition B standard.

Term	Description
High-risk backlog	Issues that need urgent action to prevent serious failure, major service disruption, or safety risks that could cause harm or legal action.
Integrated Health Communities (IHCs)	Local partnerships within the Health Board that bring together health, social care, and community services to plan and deliver care for their populations.
Occupied floor area	The total floor area of buildings in use to deliver NHS services, including spaces owned, leased, or used under agreements.
Physical condition B	Defined in the 2018 Estatecode Wales as sound, operationally safe, and showing only minor deterioration.
Reactive maintenance	Repairs carried out after a fault, failure or issue has been identified.
Reinforced Autoclaved Aerated Concrete (RAAC)	A lightweight form of concrete used in some buildings. It can pose safety risks if it deteriorates or is not properly managed.
Risk-adjusted backlog	The estimated cost to fix maintenance issues, weighted by how serious the risk is to safety, services, or compliance.
Significant-risk backlog	Repairs or replacements that need urgent action to avoid compliance concerns or risks to safe healthcare delivery.
Space utilisation	The percentage of occupied floor space that is empty or under-used as defined in the 2018 Estatecode Wales .

Term	Description
Statutory compliance	Meeting legal requirements that apply to buildings, safety systems, and estate management.
Targeted Estate Fund (TEF)	A Welsh Government capital fund that targets high priority estate risks in the NHS, including safety, compliance, and resilience. It provides £80 million (2025–27), with NHS bodies contributing 30%.

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The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out their work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Management response form



Audit Wales use only

Audited body	Betsi Cadwaladr University Health Board
Audit name	Are NHS Estates Fit for purpose?
Issue date	2025-26

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R1	The Health Board should refresh the estates strategy once it has developed its clinical plan, ensuring the estate supports the delivery of that plan. The refreshed strategy should be based on robust data and include clear delivery milestones, performance measures, and funding assumptions (paragraphs 11-13).	The Health Board will refresh its Estates Strategy following completion of the Clinical Plan to ensure the estate supports future service delivery requirements. Work will commence on establishing a robust baseline of estate information, including condition, utilisation and backlog maintenance data. The refreshed strategy will be informed by the Clinical Plan and will set out delivery priorities, milestones,	Within 12 months of Clinical Plan approval (March 2028)	Director of Estates and Environment	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		performance measures and funding assumptions to support long-term estate planning and investment decisions.			
R2	The Health Board should set up routine reporting to the Board and relevant committees on delivery of the refreshed estates strategy. Reporting should cover progress, risks, benefits, affordability and alignment with the clinical plan (paragraph 21).	<p>The Health Board will establish a reporting framework to provide regular assurance to the Board and relevant committees on the development and delivery of the refreshed Estates Strategy. Reporting will include progress against agreed milestones, key risks, anticipated and realised benefits, affordability, and alignment with the Clinical Plan. These arrangements will support effective oversight of estate investment priorities and delivery.</p> <p>1.</p>	Q4 2026/27	Director of Estates and Environment	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R3	The Health Board should review its estates governance and reporting arrangements to clarify accountability and improve oversight of estate condition, backlog maintenance, statutory compliance, performance, priorities and risks (paragraphs 17-23).	Accepted; Health Board to: <ol style="list-style-type: none"> 1. Agreed IM Lead for Estates 2. Develop a refreshed structure to provide estate assurance 'From Ward to Board'. 	R3.1 – Q4 2026/27 R3.2 – Q4 2026/27	Director of Corporate Governance Director of Estates and Environment and Director of Corporate Governance	
R4	The Health Board should streamline estates governance across the three Integrated Health Communities. This should reduce duplication, improve action tracking, and create a single forum to oversee operational estates	Agreed. Revised and fit for purpose governance to be confirmed independently of Foundations for the Future.	Q4 2026/27	Director of Estates and Environment	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	risks, compliance and performance (paragraphs 24-28).				
R5	The Health Board should strengthen estates risk management by linking local, operational, corporate and strategic risks. It should clarify ownership, remove duplication, improve action tracking and report whether mitigating actions are reducing risk (paragraphs 31-37).	Agreed. Review of risk management to be undertaken.	Q4 2026/27	Director of Corporate Governance	
R6	The Health Board should develop an approved plan and business case for a digital estates management system. The plan should improve asset, condition, utilisation,	Agreed. No commentary required	Q4 2026/27	Director of Estates and Environment	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	compliance, incident, feedback and performance data (paragraph 62).				
R7	The Health Board should develop a long-term plan to address backlog maintenance, improve estate condition and strengthen statutory compliance. The plan should prioritise high-risk issues, including outstanding fire safety actions, and identify funding options (paragraphs 54-57 and 82-86).	The Health Board will incorporate a comprehensive backlog maintenance and statutory compliance improvement plan within the refreshed Estates Strategy. This will include prioritisation of high-risk maintenance liabilities, outstanding fire safety actions, estate condition improvements, funding requirements and affordability considerations.	Aligned to approval of the refreshed Estates Strategy (March 2028)	Director of Estates and Environment	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R8	The Health Board should develop an estate rationalisation and disposal strategy. This should show underutilised or unsuitable space, support service planning, release capital where appropriate, and direct investment towards the highest-priority estate risks (paragraph 67-68).	Accepted. There are a number of prerequisites associated with and this overlaps with the estate strategy. Firstly, the corporate responsibility for space is to be clarified as noted at R4.	Aligned with R4	Aligned with R4	
R9	The Health Board should develop a comprehensive estate workforce plan. It should cover capacity, succession planning, recruitment, sickness absence, agency reduction, partnership opportunities, digital skills and future workforce requirements (paragraph 92-93).	Accepted. This can be supplemented through strategies such as the introduction of a CAFM system and also be developed as part of the Estate Strategy to ensure it is fit for the future.	Aligned to R1	Director of Estates and Environment	



Audit, Risk and Assurance Committee

ADRODDIAD GWRTH-DWYLL CH2 2026-2027 COUNTER FRAUD Q2 2026-2027 REPORT

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Danielle Kerr-Timmins, Head of Counter Fraud
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Alan Streets - Interim Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Noting
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Crynodeb Gweithredol Executive Summary

The Counter Fraud Service has continued to deliver the approved 2026/27 Counter Fraud Work Plan during Quarter 2, with performance remaining on track against agreed objectives and Key Performance Indicators. Investigation activity remained active throughout the quarter, with 12 cases concluded and 30 cases open at quarter end.

A key area of focus has been the continued development of the Parallel Investigation Protocol in partnership with People Services, aimed at strengthening governance, information sharing and coordination where fraud and employment matters overlap. This work supports a more consistent and timely organisational response to complex cases.

The service has also increased engagement with organisational stakeholders to raise awareness of fraud risks, share learning from investigations and strengthen local control environments. Proactive fraud prevention work, fraud awareness activities and support to managers have continued in line with the annual work plan.

Work undertaken during the quarter reinforces that workforce-related fraud risks remain the most significant area of fraud exposure to the Health Board. Activity has therefore continued to focus on prevention, detection and learning in these areas, whilst ensuring investigations are conducted in accordance with NHS Counter Fraud Authority standards.

There are no significant matters requiring escalation through this public report. A separate private report provides further detail regarding fraud risks and investigative activity.

The Committee is asked to:

NOTE progress against the Counter Fraud Workplan for 2026-27.
NOTE the contents of the report.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

NHSCFA – NHS Counter Fraud Authority
NFI – National Fraud Initiative
LCFS – Local Counter Fraud Specialist



1. Y SEFYLLFA / SITUATION

- 1.1 This report provides a high-level overview of counter fraud activity undertaken by the Betsi Cadwaladr University Health Board (BCUHB) Counter Fraud Team during Quarter 2 of 2026/27 and outlines progress against the approved annual work plan for the current financial year.
- 1.2

2. Y CEFNDIR / BACKGROUND

2.1 Performance Dashboard (Public Summary)

	Q3 25/26	Q4 25/26	Q1 26-27	Q2 26-27
Open Cases (end of quarter)	33	32	22	30
Cases Closed in quarter	0	13	15	12

Open cases represent a mix of allegations across workforce, patient, and primary-care-related categories.

2.2 Progress Against Annual Work Plan

Delivery of the approved 2026/27 Counter Fraud Work Plan has continued throughout Quarter 2, with activity aligned to the four NHSCFA strategic principles. Performance against agreed Key Performance Indicators remains on track.

Key developments during the quarter include:

- Continued progression of the Parallel Investigation Protocol, working jointly with People Services to strengthen arrangements for managing cases involving both employment and fraud concerns. This work is intended to improve coordination, governance, information sharing and timeliness of decision-making where parallel investigations are required.
- Increased engagement with wider organisational stakeholders to ensure fraud risks are appropriately understood, owned and managed. Fraud risk themes, learning from investigations and emerging vulnerabilities have been shared through relevant governance forums to support organisational learning and strengthen prevention activity.
- Delivery of proactive fraud prevention activity in accordance with the annual work plan, including continued work in identified workforce fraud risk areas.
- Ongoing fraud awareness and engagement activity with staff and managers, including Counter Fraud Clinics, communications activity and targeted advice to services.
- Continued investigation of allegations received during the quarter, with all cases managed in line with NHS Counter Fraud Authority standards and

appropriate consideration given to sanctions, recoveries and learning opportunities.

2.3 Strategic Fraud Risk Environment

Work undertaken during Quarter 2 has reinforced that workforce-related fraud risks continue to represent one of the most significant threats to Health Board resources. Learning from investigations and proactive exercises has been shared with senior stakeholders across the organisation to raise awareness of emerging risks and strengthen local control environments.

Particular focus has been placed on improving organisational resilience through enhanced partnership working with People Services and wider governance leads. The development of the Parallel Investigation Protocol will provide a more robust framework for managing complex cases and ensuring that fraud, workforce and governance risks are responded to in a coordinated and proportionate manner. This work will continue during Quarter 3.

2.4 Stakeholder Engagement and Governance Assurance

2.5 People and Culture Executive Delivery Group Engagement

- 2.5.1 The workforce fraud risk report was presented to the newly established People and Culture Executive Delivery Group on 15 September 2026. The report highlighted key workforce fraud risks facing the Health Board, including sickness-related fraud, secondary employment, polygamous working, conflicts of interest, consultant job plan assurance, and risks associated with agency workers not routinely recorded on ESR. The Group also received an update on the development of the Parallel Investigations Protocol between People Services and Counter Fraud.
- 2.5.2 The report was well received and provided an opportunity to raise awareness of workforce fraud risks at executive level, strengthen engagement between Counter Fraud and People Services, and promote collective ownership of the control environment. The establishment of this regular reporting arrangement provides additional executive oversight of workforce fraud risks and supports the Health Board's wider assurance framework.
- 2.5.3 Through discussion of the report, members demonstrated support for the ongoing development of the Parallel Investigations Protocol and the continued focus on consultant job plan assurance, declaration of interests compliance, and preparations for the National Fraud Initiative 2026. The presentation provides assurance that key workforce fraud risks are being actively considered within the Health Board's People and Culture governance arrangements and that appropriate escalation routes exist for emerging risks and control weaknesses.
- 2.5.4 The Audit Committee can therefore take assurance that workforce fraud risks are receiving executive-level scrutiny through the People and Culture

Executive Delivery Group, further strengthening organisational governance arrangements and supporting coordinated action between Counter Fraud, People Services and operational management.

2.6 Learning reports presented to People and Culture Committee

- 2.6.1 Workforce fraud learning and emerging themes have also been shared with the People and Culture Committee to support organisational learning and strengthen the Health Board's control environment. Discussions focused on themes identified from recent counter fraud activity, including weaknesses in recruitment and pre-employment controls, the management of individuals with previous histories of misconduct or dishonesty, information sharing between functions, the timely escalation of concerns, and the need for robust governance arrangements when managing high-risk workforce matters.
- 2.6.2 The engagement of both the People and Culture Committee and the People and Culture Executive Delivery Group provides additional assurance that workforce fraud risks, lessons learned and preventative measures are receiving appropriate oversight through established governance arrangements. This supports a coordinated organisational response to workforce fraud risks and promotes the implementation of preventative controls, policy improvements and management actions arising from counter fraud learning.
- 2.6.3 The Audit Committee can therefore take assurance that workforce fraud risks and associated lessons identified through counter fraud work are being actively considered through the Health Board's People and Culture governance structures, helping to strengthen organisational resilience and reduce the risk of future fraud, misconduct and governance failures.

2.7 Recruitment

Following a successful recruitment campaign, an appointment has been made into the role of Deputy Head of Counter Fraud and the successful candidate will commence their role in November 2026.

2.8 Forward Look

Moving into Quarter three of 2026-2027, the focus will continue to be on:

- Finalise and implement the Parallel Investigation Protocol.
- Continue raising fraud risks and learning through key governance and stakeholder forums to support organisational resilience.
- Deliver further proactive fraud exercises and targeted prevention activity focused on identified workforce fraud risks.
- Expand fraud awareness and engagement activity across the organisation.
- Continue to identify, investigate and respond to fraud risks in line with NHS Counter Fraud Authority requirements.

3. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

3.1 All Counter Fraud related risks will be addressed within the private committee paper.

There are no key risks or matters for escalation as part of this report.

4. APPENDICIES

a. Appendix A - Counter Fraud Dashboard Q1 26-27

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	1. Building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirement

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption.</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.</i>
<u>Ansawdd</u>	Galluogwyr Ansawdd Enablers of Quality	Meysydd Ansawdd Domains of Quality All Apply

<p><i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i></p> <p>Quality</p> <p><i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	All Apply Na	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<p><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u></p> <p><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></p>	Not Applicable	

<p>Effaith Amgylcheddol / Cynaliadwyedd (5Rs)</p> <p>Environmental /Sustainability Impact (5Rs)</p>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
<p>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</p> <p>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</p> <p>Armed Forces Covenant Due Regard Duty</p> <p><i>Have you considered the Armed Forces Covenant Due Regard Duty?</i></p>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<p>Asesiad o Effaith ar Ddiogelu Data</p> <p><i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i></p> <p>Data Protection Impact Assessment</p> <p><i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Relates to Counter Fraud Team progress therefore no assessment required.
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Open Investigations – End of Q2 26-27

Cases Under Investigation

30

Referrals Received

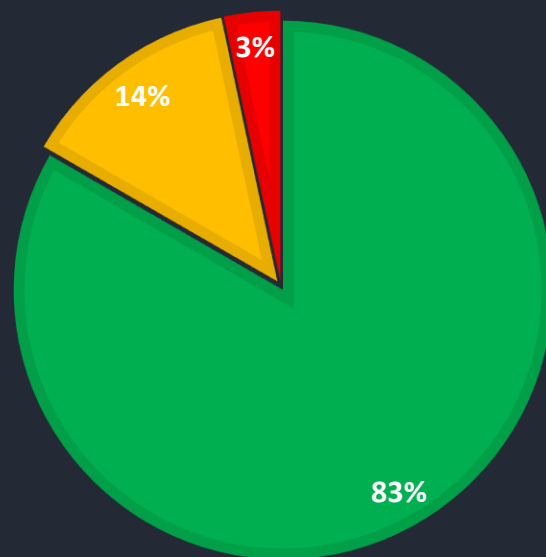
10

Interviews Under Caution

0

PROGRESS SINCE LAST UPDATE

■ Good ■ Acceptable ■ None



Fraud Type	Investigations
NHS Staff Fraud - Employee fraud	19
NHS Staff Fraud - Dental	1
NHS Staff Fraud - General Practitioner	1
NHS Patient Fraud	6
Third Party (external) Fraud	2
NHS Supplier Fraud	1



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Investigation Outcomes – Q2 26-27

Cases Closed

12

Referrals to Other Agency

3

Loss Identified

£18,207.33

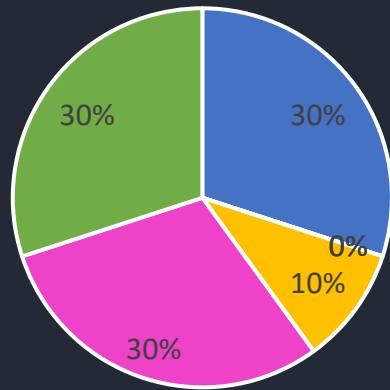
Loss Recovered

£15,577.33

Loss Prevented

£114,470.64

SANCTIONS/OUTCOMES



- Disciplinary
- Criminal Prosecution
- Caution/Community Resolution
- Civil Recovery
- Referral to Other Agency
- DoI Requested

Fraud Identified in
25.8%
Of Cases

Sanctions/Outcomes
Applied
9

Average Days to Investigate
154



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Proactive Work – Q2 26-27

E-Learning Training Compliance

92.79%

Risk Reviews

2

Presentations

0

Media Reports

3

System Weakness
Reports Completed

0

Local Proactive
Exercises Completed

1

Local Proactive
Exercises in Progress

1

Engagement Events
(People Seen)

360

Audit, Risk and Assurance Committee

LEARNING REPOSITORY

Dyddiad y Cyfarfod Date of Meeting	20 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Business Sensitive
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Chris Mewes Developer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Chris Lynes Deputy Executive Director of Nursing
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol **Executive Summary**

The Learning Repository Programme continues to progress as a key enabler of Special Measures Outcome 5, supporting the Health Board's ambition to strengthen organisational learning, organisational memory and continuous improvement.

During the reporting period, the programme has moved from development and pilot activity into operational implementation. The core Learning Repository architecture, data model, security framework and governance arrangements have been implemented within the Production environment. Initial operational use is underway, with Learning Snips published by Pharmacy and Mental Health and Learning Disability Services and further publications anticipated from Nursing and other services.

Supporting infrastructure has also been delivered through the Access & Publishing Management (APM) and Common Reference Data (CRD) solutions. These provide wider organisational capabilities for Power Platform governance, publishing controls and data standardisation. APM has been showcased across NHS Wales, while CRD has been deployed across more than 90 Power Platform environments, supporting over 60 citizen developers across approximately 20 services.

With the technical build now largely complete, the programme is transitioning to organisational implementation, adoption and benefits realisation. The focus for the next phase is therefore on:

- increasing engagement, onboarding and publication activity across services;
- embedding the Learning Repository within existing quality, safety, governance and improvement arrangements;
- progressing appropriate integration with other sources of organisational learning, including Greatix and Datix; and
- developing measures which demonstrate that learning is not only captured and shared, but is applied and results in improvement in practice.

From an assurance perspective, the key issue is now less whether the technical solution has been delivered and more whether it becomes embedded and routinely used across the organisation. Evidence of sustained adoption, integration with existing governance and improvement processes, and demonstrable benefits will therefore be important in assessing whether the programme has achieved its intended outcomes and can transition into business-as-usual arrangements.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

APM	Access & Publishing Management. A supporting solution used to manage publication channels, audience groups, access permissions and publication governance
CRD	Common Reference Data. A shared organisational data solution providing standardised reference data across the Power Platform estate
Datix	Incident reporting and risk management system used within NHS Wales
Greatix	Learning from Excellence programme designed to capture positive learning events



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Learning Repository	BCUHB's Knowledge Management System for capturing, managing and sharing organisational learning
Learning Snip	A structured unit of learning captured within the Repository and published to appropriate audiences
SME	Subject Matter Expert
OLF	Organisational Learning Forum
PID	Project Initiation Document
Power Platform	Microsoft's low-code application development platform used to build the solution
Sharewise	User-facing application used to capture learning submissions
Sharewise Review	Administrative application used to review, manage and publish Learning Snips



MEWNOSODWCH DEITL YR ADRODDIAD LEARNING REPOSITORY

1. Y SEFYLLFA SITUATION

- 1.1 The Learning Repository Programme has successfully established the core platform capability required to support the capture, review and publication of organisational learning. The foundational architecture, supporting data model, security framework and governance arrangements are now operational within the Production environment. Clinical services have commenced publication activities, providing evidence that the minimum viable workflow is functioning as intended and delivering organisational value.
- 1.2 The platform is now supporting live operational use within Pharmacy and Mental Health Learning Disability Services, with further adoption planned within Nursing and other services. The supporting APM and CRD solutions have matured into enterprise assets which support not only the Learning Repository but wider organisational digital transformation and governance initiatives.
- 1.3 Embedding into business as usual remains our next phase. Technical implementation is substantially complete, and the programme is transitioning from technical delivery towards organisational implementation and operational ownership.
- 1.4 Opportunities are being explored to align the Learning Repository with existing quality, safety, governance and improvement arrangements.
- 1.5 Work is needed to strengthen links between learning capture and dissemination processes associated with reviews, audits, incidents, concerns, thematic reviews and organisational learning forums.
- 1.6 Measures are being developed to support understanding of utilisation, dissemination of learning and organisational impact over time.

2 Y CEFNDIR BACKGROUND

- 2.1 In February 2023, BCUHB was placed into Special Measures and identified a requirement to strengthen its ability to learn from experience and continuously improve. Outcome 5 of the Special Measures Improvement Programme focuses on creating a learning and self-improving organisation. The Learning Repository Programme was established as a strategic response to this requirement.
- 2.2 The programme aims to provide a centralised knowledge management capability that captures learning from multiple sources including incidents, excellence reporting, audits, reviews and service improvement activities. The



solution is intended to improve organisational memory, support knowledge sharing, reduce duplication of learning effort and ultimately contribute towards improvements in patient safety, patient experience and service quality.

- 2.3 Development has been delivered incrementally using a phased approach, initially focusing on establishing the capture, review and publication capabilities required to support learning dissemination across the Health Board. Future phases will expand integration, automation, feedback collection, analytical reporting and AI-enabled search capabilities.

3 **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

- 3.1 The Committee is asked to note the following progress:

3.2 **Delivery Progress**

- 3.3 Core Learning Repository architecture deployed to Production. Data model, security framework and governance controls established. Successful completion of end-to-end capture, review and publication workflows.

- 3.4 Learning Snips from Mental Health , Medicines Management and Delirium published to date with additional publications in progress. Pharmacy and MHLD actively using the platform with a core editorial panel. Nursing publication channel recently established and approved for use which has significantly expanded its distribution list.

- 3.5 Ongoing engagement continues with additional services through existing governance and learning forums including a recent interest from Infection Prevention and Control.

3.6 **Supporting Enterprise Solutions and Access & Publishing Management (APM)**

- 3.7 Organisation-wide deployment completed and supports publication governance, access management and audience control.

- 3.8 Integrated with Learning Repository publishing workflows.

- 3.9 Actively supporting wider organisational services and showcased nationally across NHS Wales as an example of reusable governance tooling.

3.10 **Common Reference Data (CRD)**

- 3.11 Fully deployed and operational.



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- 3.12 Supporting more than 90 Power Platform environments.
- 3.13 Utilised by more than 60 citizen developers across approximately 20 services.
- 3.14 Providing standardised organisational reference data and supporting data quality and consistency.
- 3.15 National showcase activity planned during the next reporting period.
- 3.16 **Technical Modernisation**
- 3.17 Both Sharewise and Sharewise Review have been upgraded to utilise Microsoft's latest Modern Controls framework. This improves performance, maintainability, accessibility and alignment with current Power Platform standards while reducing future technical debt.
- 3.18 **Organisational Adoption and Integration**
- 3.19 The Organisational Learning Forum (OLF) has been identified as a potential mechanism to support oversight and promotion of learning outputs with presentations to the Forum and discussion for thematic learning..
- 3.20 Engagement with clinical divisions and corporate services continues, although participation and publication activity remain variable. Further work is required to align Repository outputs with established governance and reporting arrangements.
- 3.21 Adoption and usage measures are being developed to provide assurance regarding utilisation, dissemination of learning and organisational impact.
- 3.22 Opportunities for integration with Datix, Greatix, audits, reviews and improvement programmes continue to be explored to improve accessibility, consistency and visibility of organisational learning which is a strong end user request.
- 4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION**
- 4.1 At the time of reporting, no significant delivery risks require formal escalation.
- 4.2 The following areas continue to be actively monitored:
- 4.3 **Adoption and Engagement**
- 4.4 The long-term value of the Learning Repository is dependent on broad organisational adoption. Continued engagement and onboarding activities
-

will be required to ensure that services actively contribute learning and utilise published outputs.

4.5 **Capacity and Sustainability**

4.6 As adoption increases, resource requirements associated with service onboarding, publication review, governance and future development may increase. Appropriate operational ownership and support arrangements will be required to ensure sustainability.

4.7 **Integration Dependencies**

4.8 Future programme phases include integration with Greatix and Datix. Delivery timelines will be dependent upon the availability, accessibility and governance requirements of upstream systems and associated stakeholders.

4.9 **Benefits Realisation**

4.10 While early adoption is encouraging, the programme is still in the early stages of organisational rollout. The ability to demonstrate measurable organisational benefit and outcomes will strengthen as publication volumes and service participation increase.

4.11 Whilst early adoption is encouraging, the programme remains in the early stages of organisational rollout. The principal challenge is no longer technical delivery but achieving consistent organisational engagement, adoption and utilisation. Realisation of the full benefits will depend upon successfully embedding learning capture, dissemination and application within existing governance, quality and improvement processes. Further work is required to strengthen organisational ownership, establish sustainable business-as-usual arrangements and demonstrate how learning informs change across services and contributes to improvements in quality, safety and patient experience.

5 **ARGYMHELLION RECOMMENDATIONS**

5.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **NOTE** the progress made during the reporting period.
- **REVIEW** the assurance provided on the implementation and operation of governance arrangements, publication controls and security mechanisms within the Learning Repository platform.
- **SUPPORT** continued organisational engagement and onboarding activities to maximise adoption and benefits realisation.

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- **NOTE** the ongoing development roadmap, including expansion of service participation and future Greatix and Datix integration activity.
 - **REVIEW** the programme's transition to organisational implementation and benefits realisation, including the planned approach to increasing adoption, integration, strengthening governance and establishing sustainable business-as-usual ownership.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	<p>Digital First</p> <p>The Learning Repository Programme continues to align with the following design principles:</p> <ul style="list-style-type: none"> • User-centred design focused on accessibility and usability. • Reuse before rebuild through shared enterprise capabilities. • Security and governance by design. • Scalability through standardised Power Platform architecture. • Organisational transparency and auditable publication processes. • Single source of truth for reference data. • Continuous improvement through iterative delivery. • Support for future data analytics and AI-enabled learning capabilities. • Alignment with the Health Board's ambition to become a learning and self-improving organisation.
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	<p>This programme contributes positively towards the management and mitigation of strategic risks associated with organisational learning, quality improvement, governance and continuous improvement.</p> <p>The Learning Repository supports delivery of Outcome 5 of the Special Measures Improvement Programme and provides a structured mechanism through which learning can be captured, reviewed, shared and applied across the organisation. By establishing a centralised knowledge management capability, the programme strengthens organisational learning arrangements and supports the Health Board's ambition to become a learning and self-improving organisation.</p> <p>At present, no specific new corporate risks require escalation through the Board Assurance Framework. However, successful organisational</p>

	<p>adoption and future integration activities will remain important factors in achieving the anticipated strategic benefits of the programme.</p> <p>The successful development of the Repository provides assurance that the core technical, governance and information management infrastructure is in place. However, organisational adoption, alignment with existing governance and learning processes, and demonstrable benefits realisation remain areas requiring continued leadership focus and organisational oversight. Future assurance will be dependent upon evidence of routine use, increased engagement across services and demonstrable impact on organisational learning, quality and patient safety.</p>
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ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
	Canlyniad/Outcome:	

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ n/a
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	n/a
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

OCTOBER 2026

BCU LEARNING REPOSITORY ASSURANCE UPDATE



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Y Sefyllfa Bresennol a Sicrwydd

- Y cyfnod peilot wedi'i gwblhau'n llwyddiannus
- Ymarferoldeb yr ystorfa wedi'i brofi a'i fireinio
- Ymgysylltu positif gan fabwysiadwyr cynnar
- Dim pryderon sylweddol ynghylch llywodraethu wedi'u canfod
- Mae'r cam nesaf yn canolbwyntio ar ymgorffori yn y sefydliad a chynaliadwyedd

Current Position and Assurance

- Pilot phase completed successfully
- Repository functionality tested and refined
- Positive engagement from early adopters
- No significant governance concerns identified
- Next phase focuses on organisational embedding and sustainability



Yr Hyn sydd wedi'i Gyflawni

- Mae'r ystorfa wedi'i sefydlu ac mae'n weithredol
- Allbynnau adolygu dysgu wedi cael eu huwchlwytho a'u categoraiddio
- Cytunwyd ar drefniadau llywodraethu cychwynnol
- Adborth positif gan ddefnyddwyr sy'n manteisio ar yr adnodd
- Enghreifftiau cynnar o ddysgu ar y cyd yn dylanwadu ar arfer

What Has Been Achieved

- Repository established and operational
- Learning review outputs uploaded and categorised
- Initial governance arrangements agreed
- Positive feedback from users accessing the resource
- Early examples of shared learning influencing practice



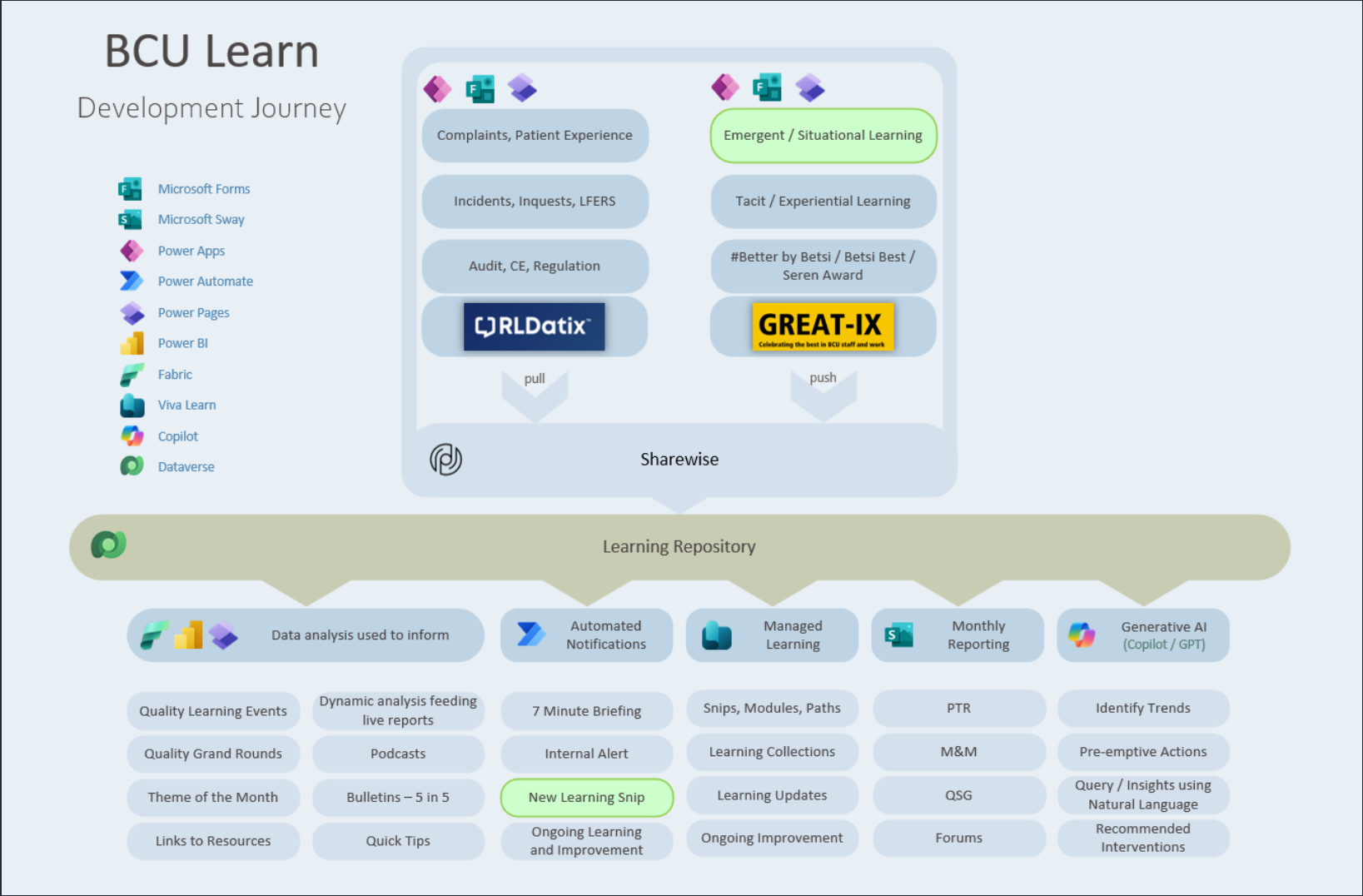
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Yr Hyn sydd wedi'i Gyflawni

What Has Been Achieved



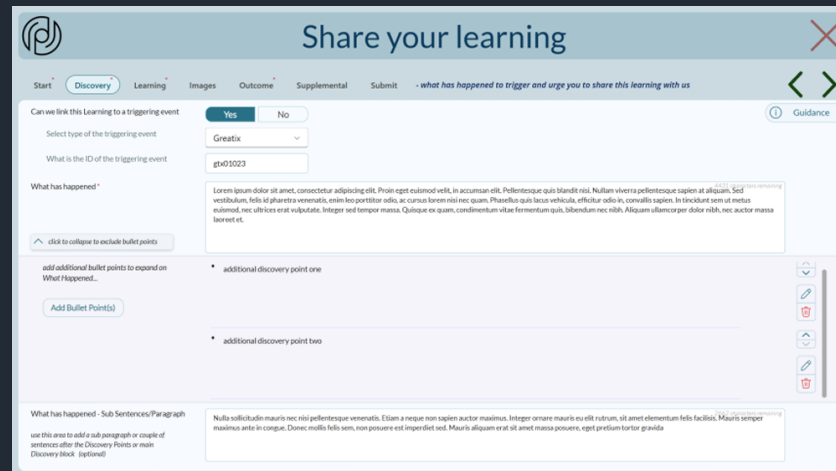
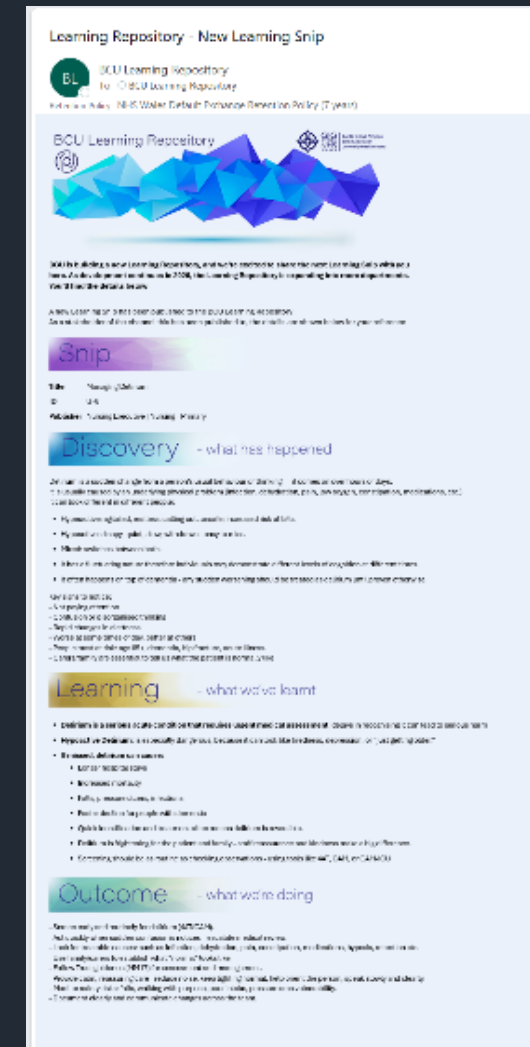
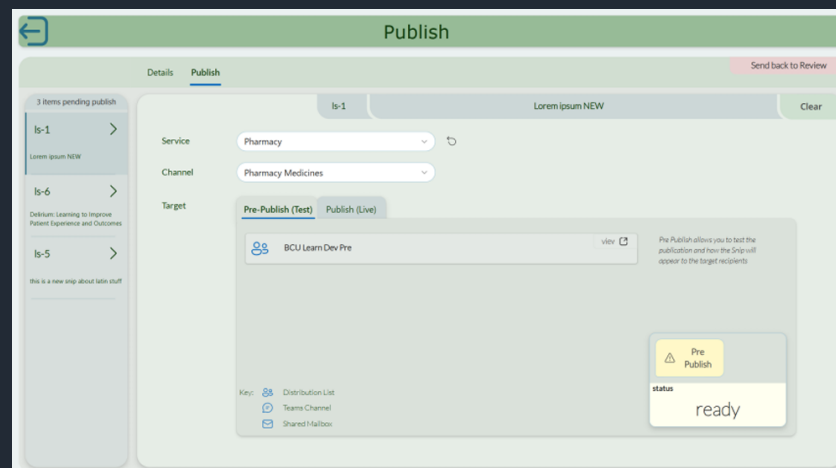
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Yr Hyn sydd wedi'i Gyflawni

What Has Been Achieved



Ymgysylltu a Defnyddio

Y Sefyllfa Bresennol

- Mae ymgysylltu'n parhau i gynyddu
- Caiff y rhan fwyaf o fynediad ei greu trwy ddiddordeb unigol ac eiriolaeth
- Nid yw defnydd wedi cael ei ymgorffori ar draws gwasanaethau yn gyson hyd yma
- Mae amrywiadau'n bodoli rhwng adrannau a thimau

Engagement and Utilisation

Current Position

- Engagement continues to increase
- Most access is generated through individual interest and advocacy
- Usage is not yet consistently embedded across services
- Variation exists between departments and teams



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Ymgysylltu a Defnyddio

Beth ydym yn ei weld?

- ✓ Chwylfrydedd cynyddol
- ✓ Defnyddwyr mynych
- ✓ Adborth cadarnhaol
- ⚠ Defnydd anghyson ar draws y sefydliad
- ⚠ Defnydd rheolaidd cyfyngedig o fewn prosesau llywodraethu

Mae'r ymgysylltu presennol yn dangos galw a gwerth canfyddedig, ond mae defnydd yn parhau i gael ei arwain gan ddiddordeb yn hytrach na chan systemau

Engagement and Utilisation

What we are seeing

- ✓ Growing curiosity
- ✓ Repeat users
- ✓ Positive feedback
- ⚠ Inconsistent organisational uptake
- ⚠ Limited routine use within governance processes

Current engagement demonstrates demand and perceived value, however utilisation remains largely interest-led rather than system-led



Risgiau a Heriau

- ⚠️ **Ymgysylltu amrywiol**
 - ✓ Hyrwyddo wedi'i dargedu ac eirioli o ran arweinyddiaeth
- ⚠️ **Dibyniaeth ar hyrwyddwyr unigol**
 - ✓ Ymgorffori perchnogaeth i strwythurau llywodraethu
- ⚠️ **Sylw anghyflawn yn y sefydliad**
 - ✓ Ehangu ffynonellau cynnwys yr ystorfa
- ⚠️ **Gwelededd cyfyngedig o ran effaith**
 - ✓ Datblygu dulliau adrodd a metrigau

Risks and Challenges

- ⚠️ **Variable engagement**
 - ✓ Targeted promotion and leadership advocacy
- ⚠️ **Reliance on individual champions**
 - ✓ Embed ownership within governance structures
- ⚠️ **Incomplete organisational coverage**
 - ✓ Expand repository content sources
- ⚠️ **Limited visibility of impact**
 - ✓ Development of reporting and metrics



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Cynllun Peilot i System Sefydliadol

- Wedi'i arwain gan Ddiddordeb
- Ymgysylltu Gwirfoddol
- Ystorfa fel Adnodd

→ Wedi'i ymgorffori i brosesau llywodraethu

→ Wedi cyfeirio ato yn ystod adolygiadau ac ymchwiliadau

→ Yn cael ei ddefnyddio fel mater o drefn wrth ganfod themâu a chamau gweithredu

→ Wedi'i integreiddio i drefniadau dysgu'r sefydliad

Pilot to Organisational System

- Interest Led
- Voluntary Engagement
- Repository as a Resource

→ Embedded within governance processes

→ Referenced during reviews and investigations

→ Used routinely when identifying themes and actions

→ Integrated into organisational learning arrangements



Llywodraethu a Gwreiddio yn y Sefydliad

Cyfnod Darganfod (Wedi'i gyflawni)	Cyfnod Mabwysiadu (Nesaf)
Platform wedi'i greu	Newid ymddygiad
Llywodraethu wedi'i sefydlu	Llywodraethu wedi'i ymgorffori
Gwersi a ddysgwyd wedi'u nodi	Gwersi a ddysgwyd wedi'u rhannu'n rheolaidd
Cyhoeddi wedi'i alluogi	Disgwyllir cyhoeddi
Mabwysiadwyr cynnar wedi cymryd rhan	Mabwysiadu ar draws y sefydliad cyfan
Galluoedd technegol wedi'u rhoi ar waith	Galluoedd sefydliadol wedi'u gwireddu

Mae'r rhaglen wedi cyflwyno'r platfform a'r trefniadau llywodraethu ategol yn llwyddiannus.

Mae'r her strategol bellach yn symud o gyflwyno technoleg i fabwysiadu ar draws y sefydliad cyfan, perchnogaeth ac ymgorffori gwersi i'w dysgu i brosesau llywodraethu a gwella rheolaidd.

Governance and Organisational Embedding

Delivery Phase (Achieved)	Adoption Phase (Next)
Platform built	Behaviour change
Governance established	Governance embedded
Learning captured	Learning routinely contributed
Publishing enabled	Publishing expected
Early adopters engaged	Organisation-wide adoption
Technical capability delivered	Organisational capability realised

The programme has successfully delivered the platform and supporting governance arrangements.

The strategic challenge now shifts from technology delivery to organisation-wide adoption, ownership and embedding learning into routine governance and improvement processes.



Llywodraethu a Gwreiddio yn y Sefydliad

Y Sefyllfa Bresennol o ran Llywodraethu

- ✓ Trefniadau llywodraethu prosiectau wedi'u sefydlu
- ✓ Mae PID wedi'i gymeradwyo ac mae trefniadau goruchwyllo ar waith
- ✓ Mae rheolaethau cyhoeddi a phrosesau adolygu ar waith
- ✓ Mae mynediad, cyhoeddi a dulliau llywodraethu diogelwch wedi cael eu rhoi ar waith trwy APM
- ✓ Mae trywydd archwilio a chofnodion cyhoeddi wedi cael eu cynnal
- ✓ Mae llif gwaith o'i ddechrau i'w ddiwedd yn weithredol o adeg cipio hyd at gyhoeddi

Cyfnod Nesaf - Llywodraethu Sefydliadol

- ⚠ Nid yw cyhoeddi gwersi a ddysgwyd wedi cael ei ymgorffori'n gyson o fewn prosesau rheolaidd hyd yn hyn
- ⚠ Mae'r ymgysylltu presennol yn dal i gael ei arwain i raddau mawr gan wasanaethau ac yn cael ei lywio gan hyrwyddwyr
- ⚠ Nid yw allbynnau dysgu yn cael eu hystyried yn rheolaidd yn ystod yr holl ymchwiliadau, adolygiadau, archwiliadau a rhaglenni gwella
- ⚠ Mae angen diffinio ymhellach o ran perchnogaeth sefydliadol yn ymwneud â mabwysiadu yn y tymor hir

Y Sefyllfa yn y Dyfodol

- Cyfeiriad o fewn fframweithiau llywodraethu ac ansawdd at yr Ystorfa Ddysgu
- Gwersi a ddysgwyd o adolygiadau, archwiliadau, ymchwiliadau Datix a rhaglenni gwella yn cael eu hystyried yn rheolaidd i'w cyhoeddi
- Disgwyliad i wasanaethau gyfrannu a rhannu gwersi i'w dysgu fel rhan o'u busnes arferol
- Adrodd yn rheolaidd ar ddefnydd o'r ystorfa, gweithgarwch cyhoeddi ac effaith ar y sefydliad
- Yr ystorfa wedi'i sefydlu fel mecanwaith dysgu sefydliadol BIPBC, nid adnodd gwybodaeth yn unig

Governance and Organisational Embedding

Current Governance Position

- ✓ Project governance arrangements established
- ✓ PID approved and oversight arrangements in place
- ✓ Publication controls and review processes operational
- ✓ Access, publishing and security governance implemented through APM
- ✓ Audit trail and publication records maintained
- ✓ End-to-end workflow operational from capture to publication

Next Phase – Organisational Governance

- ⚠ Learning publication is not yet consistently embedded within routine processes
- ⚠ Current engagement remains largely service-led and champion-driven
- ⚠ Learning outputs are not routinely considered during all investigations, reviews, audits and improvement programmes
- ⚠ Organisational ownership for long-term adoption requires further definition

Future State

- Learning Repository referenced within governance and quality frameworks
- Learning arising from reviews, audits, Datix investigations and improvement programmes routinely considered for publication
- Services expected to contribute and share learning as part of business as usual
- Routine reporting of repository utilisation, publication activity and organisational impact
- Repository established as BCUHB's organisational learning mechanism, not simply a knowledge resource



Y Camau Nesaf...

- Y chwe mis nesaf:
 - Cytuno ar berchnogaeth sefydliadol
 - Datblygu metrigau a dangosfyrddau ar gyfer defnydd
 - Integreiddio i brosesau adolygu dysgu thematig
 - Gwellu gwelededd a dulliau hyrwyddo arweinyddiaeth
 - Sefydlu adrodd rheolaidd ar ddefnydd ac effaith

Mae'r cynllun peilot wedi dangos bod yr Ystorfa Ddysgu yn fecanwaith dichonol a gwerthfawr i ategu dysgu sefydliadol.

Er bod ymgysylltu'n dal i fod ar gam cynnar a'i fod yn cael ei yrru gan ddiddordeb unigol yn bennaf ar hyn o bryd, mae twf sefydlog o ran defnydd ac adborth positif yn cynnig hyder bod yr ystorfa yn barod i symud ymlaen at y cam nesaf yn ei datblygiad.

Mae gwaith erbyn hyn yn canolbwyntio ar ymgorffori'r ystorfa i systemau llywodraethu a dysgu'r sefydliad er mwyn cynnal mabwysiadu cynaliadwy a chyson ar draws y Bwrdd Iechyd.

Next Steps...

- Next 6 months:
 - Agree organisational ownership
 - Develop utilisation metrics and dashboards
 - Integrate into thematic learning review processes
 - Increase leadership visibility and promotion
 - Establish routine reporting on use and impact

The pilot phase has demonstrated that the Learning Repository is a feasible and valuable mechanism for supporting organisational learning.

While engagement remains at an early stage and is currently driven primarily by individual interest, steady growth in utilisation and positive feedback provide confidence that the repository is ready to move into its next phase of development.

Work is now focused on embedding the repository within organisational governance and learning systems to support sustainable and consistent adoption across the Health Board.

