

Bundle BCU Audit Committee 17 February 2026

- 0 09:30 - OPENING BUSINESS - OPEN SESSION
- 1 AC26.1 Welcome and apologies for absence
Paul Lambert Committee Chair
- 2 AC26.2 Declarations of Interest
Paul Lambert Committee Chair
- 3 AC26.3 Unconfirmed minutes of meeting held on 16.12.25
Paul Lambert Committee Chair
AC26.3 Minutes Audit Committee 16.12.25 v.02 unconfirmed public
- 4 AC26.4 Matters arising and summary action log
Paul Lambert Committee Chair
AC26.4 Summary Action Log updated 11.2.26
- 5 GOVERNANCE
- 6 09:35 - AC26.5 Update on outstanding audit recommendations
Angela Wood Executive Director Nursing and Midwifery in attendance
AC26.5 Dir N&M Recommendations report Audit Committee - presentation Feb 26
- 7 09:50 - AC26.6 Statutory Compliance report
Glesni Driver Head of Statutory Compliance and Inquiries
AC26.6a Compliance report 17.02.2026 v1.00
AC26.6b App 1 - IA Open Unsatisfactory v1.00
AC26.6c App 2 - IA Open Limited Assurance v1.00
AC26.6d App 3 - AW open
AC26.6e App 4 - Recs for Exec closure v1.00
AC26.6f App 5 - IA for AC closure v1.00
AC26.6g App 6 - AW for AC closure v1.00
AC26.6h App 7 All overdue v2.00
- 8 10:00 - AC26.7 Corporate Governance report
Pam Wenger Director Corporate Governance
AC26.7a Corporate Governance report
AC26.7b Workplan for Audit Committee (Live Version as at 10.02.25)
AC26.7c Appendix 1 - Corporate Governance report - LFERs - Feb 2026
- 9 10:10 - AC26.8 Director's accountability statement 2026/27
Pam Wenger Director Corporate Governance
AC26.8a Director Accountability Statement v1.0
AC26.8b Directors Annual Accountability Statement 26-27
- 10 10:20 - AC26.9 Annual Report 2025/26 arrangements
Pam Wenger Director Corporate Governance
AC26.9 Annual Report 2025-26 arrangements
- 11 10:30 - AC26.10 Corporate Risk Register
Pam Wenger Director Corporate Governance
AC26.10 Corporate Risk Register Report February 2026 Public V2
- 12 10:40 - AC26.11 Governance and Accountability Framework
Pam Wenger Director Corporate Governance
AC26.11 Governance and Accountability Framework
AC26.11a Master Standing Orders - Approved Audit Committee 4 March 2025
AC26.11b Governance and Accountability Framework - Schedule 1 - SORD 04-02-26 v1.3
AC26.11c Schedule 2 - Standing Financial Instructions - Approved 25.09.25 V1.0

- 13 FINANCE
- 14 10:55 - AC26.12 Finance Conformance report
Russ Caldicott Executive Director Finance
AC26.12 Financial Conformance Report - Q3 2025-26 FINAL
- 15 11:05 - AC26.13 Counter Fraud report
Danielle Timmins Head of Counter Fraud
AC26.13a Counter Fraud report PUBLIC - Q3 25-26
AC26.13b Counter Fraud Appendix A Dashboard Q3 25-26 PUBLIC
- 16 11:10 - Break
- 17 INTERNAL AUDIT
- 18 11:25 - AC26.14 Internal Audit Progress Report
Dave Harries Head of Internal Audit
AC26.14a IA progress report cover sheet February 2026
AC26.14b BCUHB Audit Committee IA progress report February 2026
- 19 EXTERNAL AUDIT
- 20 11:40 - AC26.15 External Audit Progress report
Fflur Jones / Andrew Doughton Audit Wales
AC26.15 BCUHB Audit Wales Update (February 2026)
- 24 11:50 - CLOSING BUSINESS
- 25 AC26.16 Agree items for referral to Board / other Committees and for Chair's AAA report
Paul Lambert Committee Chair
- 26 AC26.17 Review of meeting effectiveness
Paul Lambert Committee Chair
- 27 AC26.18 Date of next meeting 21.4.26
Paul Lambert Committee Chair
- 28 Resolution to exclude the Press and Public
"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed minutes of the Audit Committee
held on 16 December 2025
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	Title
Paul Lambert	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member
In Attendance	
Tehmeena Ajmal	Chief Operating Officer (part meeting)
Clare Barwise	Post Payment Verification (PPV) Location Manager, North Wales Shared Services (NWSSP) (part meeting – via Teams)
Russell Caldicott	Executive Director of Finance (via Teams)
Nesta Collingridge	Head of Risk Management (part meeting)
Clara Day	Executive Medical Director (part meeting)
Glesni Driver	Head of Compliance and Inquiries (part meeting – via Teams)
Dyfed Edwards	Health Board Chair (part meeting)
Matt Edwards	Auditor, Audit Wales (part meeting – via Teams)
Dave Harries	Head of Internal Audit, NWSSP
Fflur Jones	Performance Audit Lead, Audit Wales
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Amanda Legge	All Wales PPV Manager, NWSSP (part meeting – via Teams)
Justine Parry	Acting Chief Digital and Information Officer (via Teams)
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Diane Davies	Corporate Governance Manager
Observer	
Jody Evans	Risk Manager

PRELIMINARY MATTERS

AC25.154 Welcome and Apologies

Apologies were received for Independent Members Dyfed Jones and Rhian Watcyn Jones, Pam Wenger - Director of Corporate Governance and Danielle Timmins - Head of Counter Fraud.

AC25.155 Declarations of Interest

No declarations of interest were raised at the meeting.

AC25.156 Unconfirmed minutes of the meeting held on 21.10.25

It was agreed that the minutes of the meeting held on 21 October 2025 were a true and accurate record.

AC25.150 Matters Arising and Action Log

The Committee agreed to close the action that was proposed for closure noting the update provided.

The Committee Chair stated his preference to ensure realistic timescales were agreed on actions going forward.

GOVERNANCE

AC25.158 Update on Outstanding Audit Recommendations

The Chief Operating Officer (COO) presented the item which provided an updated position on outstanding actions. In the discussion which ensued the following was noted:

- The COO emphasised that learning highlighted within the recommendations would inform future developments
- The Executive Medical Director advised that Waiting List Initiative processes would be the subject of process change that was being worked through with staff in job planning discussion.
- The Head of Internal Audit highlighted that consideration of processes needed to morph whilst structural changes were taking place.
- As significant structural change was expected it would be important to ensure strong operational and clinical interfaces were in place and embedded into governance processes.
- The Audit Committee Chair was keen to ensure that all essences of issues were well captured and accurately tracked individually. Attention should also be focussed on appropriate expertise and identification of gaps. Focus on effective processes was critical.
- A discussion ensued on whether the Planned care risk should be separated out to ensure more focussed attention to all the inherent risks and therefore ensure clarity on appropriate mitigation and actions being undertaken. The impact on the Board Assurance Framework was acknowledged.

It was resolved that the Committee

Noted the updates provided.

AC25.159 Progress on the Consultant Job Planning Internal Audit Report

The Executive Medical Director presented the item. In the discussion which ensued the following was highlighted

- Whilst Welsh Government had targeted 90% compliance on consultant job planning by Sept 2025, BCUHB had currently signed off 46% with a further 13% awaiting. There was significant variance across the organisation's areas.
- A Job Planning protocol had been co-developed and a Medical Workforce Group would own job planning progression. A revised trajectory had been proposed for 90% sign off by the end of quarter 1 2026/27.
- It was important to recognise that the Foundations for the Future programme changes would more clearly define service needs and therefore Job Planning would be a work in progress over the next 12 to 18 months.

- In response to the Health Board Chair, the Executive Medical Director advised that there was a need to facilitate improved regional management.
- The Executive Director of Finance advised that he would meet with the Executive Medical Director to evaluate how changes in policy might affect the cost envelope available. She acknowledged that there was work to be done in analysing establishment levels and management responsibility allowances.
- The Head of Internal Audit supported the approach being undertaken and drew attention to the need to address under and over payments which were of concern.
- In response to the Committee Chair's concern regarding the effectiveness of staff appraisal systems, the Executive Medical Director enlarged on complexities within consultant performance management, especially in the area of professional leadership, which was under consideration and being moved forward.

It was resolved that the Committee

Noted the revised plan for Senior Doctor Job Planning.

Tehmeena Ajmal left the meeting

AC25.160 Clinical Audit Improvement Plan

The Executive Medical Director presented the item. In the discussion which ensued the following was highlighted

- Improvements to processes were being introduced with areas of highest risk being prioritised for action and escalation where required.
- The Committee Chair emphasised the importance of ensuring that there was a coherent handle on the totality of data available to aid decision making, especially whilst organisational structures changed. He sought clarity on with whom this responsibility lay within BCUHB as he felt improved grip, with potentially the use of Artificial Intelligence, could be of significant benefit to the organisation in identifying issues and making improvements. Business Intelligence would extremely important to taking this forward.
- In response to the Head of Internal Audit's question regarding nursing clinical audits, the Executive Medical Director advised that most were multi disciplinary due to the nature of their instigation. Tier 3 local clinical audit outputs required more understanding.
- In response to the Health Board Chair, the Executive Medical Director advised on areas the Board should take most notice of regarding patient safety, such as mortality trends. She assured that whilst this was being currently worked through, there were no areas of immediate concern highlighted.
- Assurance was provided that all Red 'RAG' rated areas within the plans provided were being prioritised to ensure clarity and action.

It was resolved that the Committee

Supported the process outlined.

Noted the Tier 1 and Tier 2 Clinical Audit 2025/26 forward plans provided.

AC25.161 Statutory Compliance Report



The Head of Statutory Compliance and Inquiries presented the item and explained the approval processes undertaken in compiling the report. The following was highlighted in discussion of the report

- The Acting Chief Digital and Information Officer provided assurance that she was currently undertaking responsibility for the digital portfolio, which would include any compliance issues arising in this area.
- In regard to clarification on Ministerial Directives, the Head of Internal Audit stated that these would be planned into the internal audit programme during 2026/27.
- The Committee Chair stressed the importance of escalating the cultural value of the internal audit process within the organisation as an important beneficial management tool, especially at an operational level.
- In response to the Health Board Chair, the Head of Statutory Compliance and Inquiries advised that governance was a common theme of concern. The Corporate Governance Directorate were continuing to develop and promote a hub of resources, to support improvement within these areas.
- The need to support and nurture cultural change was highlighted.

ACTION: Head of Statutory Compliance and Inquiries to provide greater detail on progress of all open Ministerial Directives in future reports.

It was resolved that the Committee NOTED the Statutory Compliance report.

AC25.162 Corporate Policy Management Policy Process

The Head of Statutory Compliance and Inquiries presented the item. The following was highlighted in discussion of the report

- The ensuing consultation route and presentation to the Board for final approval was clarified.
- It was confirmed that a programme of staggered review dates would be in place, thus avoiding potential excessive capacity peaks.

It was resolved that the Committee

APPROVED the proposed policy management process and updated draft Corporate Policy Management Policy for further consultation and submission to the Board in due course.

AC25.163 Board Assurance Framework

The Head of Risk Management presented this item. The following was highlighted in discussion of the report

- Work needed to be done to close areas within the BAF where sufficient assurance was considered to be in place.
- There was a digital theme risk emerging. The Acting Chief Digital and Information Officer advised that she was now moving these forward and gave brief updates on resource issues which were impacting this and advised these were not related to recent WG interest in data issues.

- In response to the Committee, the Executive Medical Director expanded on the connection between strategic medical technology horizon scanning, NICE and Value & Sustainability work across the NHS.
- Following the Board Chair's concern regarding the efficacy of risk scrutiny, the Head of Risk Management clarified the operational processes in place leading up to presentation to the Committee.
- In discussion of Member's concern with progress and/or inertia of risk movements, the Head of Risk Management advised that when the new risk management software was implemented potentially from February 2026, monitoring and scrutiny would be more effective within a year (*post meeting note: Risk Management Software is currently out to procurement with no date yet fixed for implementation*).
- The Executive Director of Finance welcomed the improvements made to the culture of risk management visibility and challenge however, he cautioned that delegation should not obscure the need to take action on the risks presented. He also called for more differentiation between the BAF and Corporate Risk Register.
- The Committee Chair congratulated the Head of Risk Management in changing the culture of risk within the organisation, especially given its size, and wished her every success in her new role outside NHS Wales on behalf of the Board.

It was resolved that the Committee

NOTED the Board Assurance Framework as presented and intention to further update on receipt of the three year plan.

AC25.164 Corporate Governance Report

The Head of Corporate Governance presented this item. The following was highlighted in discussion of the report

- There was ongoing work to improve processes and systems to collate Declarations of Interest
- Internal Audit raised concern with the repetitive theme of late paper submissions across all Committees to the Directorate of Corporate Governance for publication within agreed timescales. Board members concurred that this had a detrimental impact on their arrangements in preparing for meetings. The Head of Corporate Governance advised that new templates and supportive guidance were being rolled out in the new year to improve the quality of submissions going forward.

It was resolved that the Committee

NOTED

- the breaches to the Standing Orders;
- the Declarations of Interests;
- the summary of business considered in private session on 21 October 2025;
- the Forward Workplan;

RECEIVED an update on the Mental Health and Society

Dyfed Edwards, Clara Day and Nesta Collingridge left the meeting

FINANCE

AC25.165 Finance Conformance Report

The Executive Director of Finance presented this item. The following was highlighted in discussion of the report

- The Executive Director of Finance drew particular attention to the focus on grip being applied within the Centre Integrated Healthcare Community, continued concerning level of overpayments with more attention being focussed on termination processes and pleasing 97% conformance with public sector payment policy.
- In regard to the length of cases managed by the Legal & Risk Pool, he clarified that some of these related to obstetric cases in which interim payments were necessary prior to reaching final settlement agreements which were dependent on individual patients' assessments.
- In response to concern regarding the disappointing level of learning from events reports provided which had resulted in penalties being applied,
- In discussion of the breached contracts data provided, assurance was given that closer examination revealed that not all were related to the Digital Directorate, but rather services utilising digital technology. The Acting Chief Digital and Information Officer offered to assist the Executive Director of Finance in examining these further.

ACTION: Whilst it was acknowledged that there had been a reduction in outstanding learning reports, the Deputy Director of Legal Services would be contacted to provide greater assurance that patient experience remained a focus to learn from and processes were in place to avoid the application of penalties.

It was resolved that the Committee

NOTED the report

APPROVED the Losses and Special Payments (July to September 2025)

Amanda Legge and Clare Barwise joined the meeting for this item only.

AC25.166 Post Payment Verification Update

The Executive Director of Finance presented this item. The following was highlighted in discussion of the report

- The Independent Members present requested that future Board agendas feature greater attention to Primary Care, as their actions resulted in financial impacts to the organisation. It was acknowledged that the Planning, Population Health and Partnerships Committee was now scheduled to include more focus on Primary Care within its business, albeit there was not a cohesive handle on Primary Care data. The Executive Director of Finance welcomed any suggestions for inclusion within reporting which he would explore further.
- In response to the Head of Internal Audit's questioning of potential internal control risks, given BCU was a GMS outlier in 2024/25, the All Wales PPV Manager advised that this was not an area of concern however, assurance was provided that Counter Fraud would be alerted should a concern arise.

It was resolved that the Committee

NOTED the assurance report

INTERNAL AUDIT

AC25.167 Internal Audit Progress Report

The Head of Internal Audit presented this item. The following was highlighted in discussion of the report

- The Committee Chair advised that reasonable assurance reports would be received at the Committee and those of limited and no assurance would be discussed going forward.
- Following discussion on the theme of delay in attaining evidence to support management responses to internal audit reports, the Committee Chair requested that where there were any future delays, the responsible Executive would be invited to attend the Committee. The Executive Director of Finance agreed to share this directive at the Executive Committee.
- Discussion ensued on the deficiency in embedding learning within the organisation, including following discussion of reports at other Committees. The Committee Chair emphasised the importance of implementing learning and embedding at an operational level. It was understood that the Director of Corporate Governance was in the process of strengthening this area within the organisation through her team.
- In regard to the concern on non-compliance with contract management within directorates – especially corporate, broader discussion ensued on significant budget management accountability issues. The Committee Chair **stressed** this must be addressed, the Executive Director of Finance advised the need to ensure that appropriate accountability was signed up to and actioned had been escalated to the Chief Executive as a significant issue.
- Attention was particularly drawn to the additional reviews commissioned in year, which included capital developments and contracts.

ACTION:

- The Head of Corporate Governance to share feedback with the Director of Corporate Governance on the intention to invite Executives to future meetings where evidence to support management responses has not been provided in order that appropriate arrangements are agreed.
- 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.

It was resolved that the Committee

NOTED the progress report.

APPROVED the following amendments to the internal audit plan for 2025/26:

- Removal from the plan:
 - Workforce Planning (BCU-2526-23)
 - Integrated Regional Care Fund (IRCF) Projects (BCU-SSU-2526-35)
 - Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (BCU-SSU-2526-39)
- Additions to the plan:
 - Major Project Governance and Contract Management Arrangements (BCU-SSU-2526-43)
 - Centre for Mental Health and Society (BCU-2526-44)
 - Integrated Audit Plan – Nuclear Medicine (BCU-SSU-2526-45)
 - Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub



(BCU-SSU-2526-46)

EXTERNAL AUDIT

AC25.168 External Audit Progress Report 4960A2025

The Audit Wales Performance Lead Fflur Jones presented this item. The following was highlighted in discussion of the report

- An update on Audit Wales current and planned accounts, as well as performance audit work at Betsi Cadwaladr University Health Board was provided.
- The Annual Structured Assessment report was expected to be provided within the next few days.
- The Committee Chair commended the approach to the reviews being undertaken.

It was resolved that the Committee

RECEIVED the progress report.

NOTED that the Planned Care management response had been received.

AC25.169 Audit Wales - BCUHB Awyr Las 24/25 Audit Plan 5141A2025

Matt Edwards, Audit Wales joined the meeting for this item to advise good progress had been made on the Awyr Las 2025 Audit Plan report provided which was expected to be reported at the next Charitable Funds Committee on 27th January 2026.

It was resolved that the Committee

RECEIVED the Awyr Las 24/25 Audit Plan.

COUNTER FRAUD

AC25.170 Local Counter Fraud Service Report

The Executive Director of Finance presented the item. In the discussion which ensued it was agreed that the increasing instances of time sheet fraud should be referred to the People and Culture Committee to explore further.

ACTION: Refer prevention of time sheet issues and working whilst sick to the People and Culture Committee to explore further.

It was resolved that the Committee

RECEIVED the report

CLOSING BUSINESS

AC25.171 Agree items for referral to Board / other Committees

- Referral of timesheet fraud and working whilst sick issues to the People and Culture Committee for further exploration
- Increase sight of Primary Care within Board agendas.
- Embedded learning remained an issue of significance, which the Director of Corporate Governance was actively addressing with her team.
- Raise the issue of non-compliance with budget responsibility sign off agreements with a significant number of Senior Leaders and managers – which, whilst having



been escalated to the Chief Executive, needs to be drawn to the attention of Board members as an essential and remunerated element of these important roles.

AC25.172 Review of meeting effectiveness

The following feedback was received

- Effective clarity provided on the capturing of actions.
- Improved accountability of Executives will be beneficial in regard to submissions of timely management responses which will assist to improve Internal Audit report turnarounds.
- The emphasis on holding to account was welcomed.
- Time management of the agenda was commended.

AC25.173 Date of next meeting - 17.02.26

Resolution to exclude the Press and Public

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Audit Committee Action Log (Public)

Updated 11.2.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
REMAIN OPEN						
1	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.	Dave Harries	May 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.
2	AC25/136.1	21.10.25	Statutory Compliance Report 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.	Pam Wenger Russell Caldicott	Feb 26	Remain Open 10.2.26 The Report is in the process of being finalised and will be brought through to the next meeting. 1.12.25 Chief Executive confirmed at the Board meeting on 27.11.2025 that the Commissioning Assurance

						Framework was in draft.
3	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	Remain Open 10.2.26 This now falls under the 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.
4	AC25/32.1	04.03.25	Information Governance and Records Management Position 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.	~~Pam Wenger~~ ~~Dylan Roberts~~ Justine Parry	Oct 25 Revised timescale Apr 26	Remain Open 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 PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team. 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. 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.
ACTIONS PROPOSED FOR CLOSURE						
5	AC25/109.1	19.08.25	Matters Arising and Action Log Director of Corporate Governance to discuss the Contracted Patient Services Review with the Chief Executive, circulate a briefing outside of the meeting and further consideration of progress to be reported at the next Committee meeting.	Russell Caldicott	Dec 25	Propose to close (this action is superseded with 136.2) 10.2.26 This item is the same as 136.2 so suggest this is closed to avoid duplication. Meeting has taken place with the Director of Finance and Director of Nursing. 6.1.26 Meeting to be arranged with Lead Executives before next meeting This now falls under the remit of the Executive Director of Finance to update in the meeting. 4.12.25 Progress update pending 11.09.25 Director of Corporate Governance to discuss with the Chief Executive and report back to the Committee.
6	AC25.161	16.12.25	Statutory Compliance Report Head of Statutory Compliance and Inquiries to provide greater detail on progress of all open Ministerial Directives in future reports.	Glesni Driver	February 26	Proposed for closure This has been noted. The information presented to the December Audit Committee reflected the agreement in place from the Audit Committee meeting on 8 May 2025 where there would

						be a six-monthly report to Audit Committee on newly-published WHCs and MDs
7	AC25.165	16.12.25	Finance Conformance Report Whilst it was acknowledged that there had been a reduction in outstanding learning reports, the Deputy Director of Legal Services would be contacted to provide greater assurance that patient experience remained a focus to learn from and processes were in place to avoid the application of penalties.	Matt Joyes	Matt to confirm	Proposed for closure There is an updated paper included as an Appendix to the Corporate Governance Report.
8	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 Feb 26	Suggest Close 09.02.26 On the 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. 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. 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. 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. 04.03.25 In relation to the Centre for Mental Health it has been agreed to commission a review and this will come back to Committee. 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) 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.
Closed Actions (as agreed at meeting on 17.12.25)						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	AC25/70.1	08.05.25	Final Internal Audit Reports (Clinical Audit Report) Interim Executive Medical Director to take the Clinical Audit Plan to the QSE Committee and bring this back to the Committee in due course to approve the Clinical Audit Plan and receive assurance on progress.	Sree Andole Clara Day	October 25	Agreed for closure 17.12.25 – Agenda item discussed at meeting 16.12.25 Agenda item AC25.160 28.10.25 The Clinical Improvement Plan was deferred from the October to the December meeting and is included on the agenda for the December Audit Committee. 11.09.25 The Clinical Audit Improvement Plan is included on the agenda for the October 25 meeting, propose this action is closed. 07.07.25 The Clinical Audit Plan was received by the QSE Committee in July, further work is required and this will be received by the Audit Committee in October 25.

2	AC25/110.1	19.08.25	Statutory Compliance Report Progress on Consultant Job Planning to be closely monitored by the People and Culture Committee and assurance provided back to the Audit Committee in due course.	Clara Day	Dec 25	Agreed for closure 17.12.25 – Agenda item discussed at meeting 4.12.25 Agenda item AC25.159 (Noting also discussed at P&C Committee on 4.12.25 (Item PC25.133)). 06.10.25 This is due to be considered at the People & Culture Committee in December 25 and an update will be provided at the next Audit Committee. 11.09.25 An update was provided to the People and Culture Committee in August 2025, this is due to go back to the People and Culture Committee in December 2025 once the new Executive Medical Director has commenced in post and will then come back to the Audit Committee.
3	AC25/136.3	21.10.25	Statutory Compliance Report Chief Operating Officer to refer to Audit Wales recommendation 1364 in relation to Urgent and Emergency Care when presenting to the Committee in December 2025.	Tehmeena Ajmal	Dec 25	Closed 21.10.25 To consider as part of agenda item AC25.158 Update on Outstanding Audit Recommendations and to consider closure if the Committee is content.
15	AC25/142.1	21.10.25	External Audit Progress Report Chief Operating Officer to join the December meeting to provide an update on the Internal Audit	Tehmeena Ajmal	Dec 25	Closed 21.10.25 Agenda item AC25.158 Update on Outstanding Audit Recommendations - consider

			recommendations, the thematic work on Urgent and Emergency Care and the recent Planned Care and Unscheduled Care reports.			closure if the Committee is content.
16	AC25/69.2	08.05.25	Internal Audit Progress Report Executive Director of Finance and Head of Internal Audit to meet and discuss the Scheme of Reservation and Delegation further to align the process and gain clarity on the narrative.	Russell Caldicott Dave Harries	August 25 Revised timescale Dec 25	Closed 21.10.25 27.11.25 A paper was provided to the Board on 27.11.25 and discussed in private session (Agenda item 25.230) 14.10.25 The Director of Performance and Commissioning has responsibility for this element, as this role is currently vacant the Director of Finance will include a report on contracts within the Health Board Finance Report and at this point the action is expected to be closed. 19.08.25 It was agreed during the meeting that this action should remain open as the delegation to Officers has not yet taken place. It was noted by the Head of Internal Audit that for the Health Board to be compliant in 2025/26 there is a need to go through the process to confirm the formal delegation for sign off of healthcare agreements. 08.07.25 Discussions have concluded, the report is compliant with SFIs which would have satisfied



						the requirement to approve contracts however the Executive Director of Finance was on leave and the report was not taken by Committee. This will be corrected moving forward. The report as produced, requires presentation to the Committee and subsequent recommendations for approval to Health Board to ensure Compliance and delegation to Officers for 2025/26.
17	AC25/141.1	21.10.25	Internal Audit Progress Report Committee Chair, Vice Chair and Head of Internal Audit to meet with the Chief Executive to raise concerns around Internal Audit report turnaround times and the lack of sufficient evidence being provided.	Paul Lambert Urtha Felda Dave Harries	Feb 26	Closed 21.10.25 13.11.25 Urtha Felda advised that meetings had taken place with the Chief Executive, and also Internal Audit, in which a new approach to managing Executive Directors' standard of evidence had been agreed. The Director of Corporate Governance referenced this at the Committee development session on 4.11.25 and also confirmed in the Audit Committee Chairs Report to the Board
18	AC24.60.1.1 0	07.05.24	Internal Audit Progress Report Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate	Urtha Felda Pam Wenger Philippa Peake-Jones	June 25 Revised timescale Dec 25	Closed 21.10.25 27.11.25 this item was raised at the Chairs Advisory Group 06.10.25 This item has been included on the agenda for the next

			Governance to raise in the Chairs Advisory Group as an emerging topic.			Chairs Advisory Group for discussion. 29.07.25 Verbal update by Vice Chair to be provided during the meeting. 10.04.25 This has been included on the agenda for the next Chairs Advisory Group which is due to take place on 24.04.25. 08.01.25 The Head of Corporate Affairs has included this on the agenda for the next Chairs Advisory Group for discussion which is due to take place on 26.02.25. This meeting has subsequently been stood down and this item will roll over to the next meeting. 08.10.24 The recommendations included in the Lessons Learnt Audit Report have been shared with the Chair, this will be discussed at the Chairs Advisory Group in October and the Chair will provide a verbal update at the Audit Committee in November. 12.09.24 This will be discussed at the next Committee Chair's Meeting. 02.09.24 Update to be provided during the meeting. 18.07.24 To be raised at the next meeting in August 2024 as part of



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

						feedback from the Audit Committee Chair.
19	AC25/137.1	21.10.25	Revised Policy Management Process Final version of the Policy management Process to be presented to the Committee in in December 2025 for onward approval by the Board in January 2026.	Pam Wenger Glesni Driver	Dec 25	Closed 21.10.25 4.12.25 Refers to agenda item AC25.162 Policy Management Process

Audit Committee

Executive Director of Nursing and Midwifery Update Presentation on Open Audit Recommendations



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

17th February 2026

Internal Audit - Limited audit recommendations

Report Title	Year	Number of report recommendations	Number of limited assurance recommendations	Number of recommendations implemented / complete	Total number of report recommendations open
Falls Management - Follow up	2025	14	14	11	3
Complaints management	2025	4	2	1	3
Patient Experience	2025	2	0	1	1



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Falls Management - Follow up

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Health Board Therapists use a separate electronic system (Therapy Manager) for recording patient management. Their assessments, which are almost identical to the Falls and Bone Health Multifactorial Assessment (FBHMA), are not currently accessible to nursing staff. Therapists are encouraged to update the FBHMA to improve the Multidisciplinary assessment process. However, our sample review has not confirmed that this is being requested.	Therapists are present daily on the wards and attend board rounds. Pertinent information relating to mobility, transfer and function will be shared and communicated at Board Rounds to enable nursing staff to update the FBHMA assessment. Staff will also update WNCR with changes in function / mobility status.	AHP Directors, via the Strategic Falls Group, are exploring how all Therapists across BCUHB can access and update the FBHMA consistently, ensuring a more integrated and standardised approach to falls risk management. Implementation date 31-3-26
To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate.	- Increasing trend in both Patient Handling and Falls training over last 12 months - Appointment of two manual handling advisors Progress on this action continues but has been slow due to the training for University students and the need for the whole manual handling team to support this intensive period which has been hampered by long term sickness and manager investment into the Developmental Advisor posts.	A review is underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring the training is accurate. Implementation date – 31-3-26
Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher.	Opportunities to upskill Manual Handling Champions to support the Corporate Team with local delivery of refresher training to reduce the number of colleagues required to attend classroom-based refresher being explored.	Opportunities for a train the trainer course and potential funding which may support costs are being explored. Implementation date – 31-3-26



Complaints Management

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Although complaints training is being delivered on an ad hoc/request basis and supplements that set out in Health Board Policy, no records are being kept by the complaints team. The training prospectus is not advertised on Intranet enabling staff to book on complaints specific training.	Complaints training is delivered albeit on an ad hoc basis. The training supplements the Health Board Policy. There is a plan to formalise the training and this will align with the new framework, Listening to People, which comes into affect from 1st April 2026. Work is being undertaken nationally to devise a training programme to support the rollout of the new Listening to People Framework.	A formal training programme will be systematically rolled out across the Health Board. A log of attendance will be monitored, and areas of low attendance will be escalated. Implementation date 1-4-26
Learning and Improvement Plan action plans – Compliance with Policy No supporting evidence was noted in our review of DATIX to confirm the closure of actions, despite these being recorded as complete and closed. The Health Board is in the final stages of developing a dedicated learning repository to support evidence gathering on agreed learning actions identified in the complaints process.	BCUHB has maintained the position of timely closure of complaints. There is a robust governance process for review and sign off of investigations and responses, which incorporates learning and action plans. The governance process will be enhanced to ensure that learning and actions identified are undertaken, embedded and closed. Following a successful pilot the dedicated learning repository is being prepared for full rollout across all departments in 2026.	Integrated concerns and complaints policy section 16.7 is being changed, to provide more detailed narrative to identify the responsibility for embedding and evidencing learning. The dedicated learning repository to support evidence gathering on agreed learning actions identified in the complaints process is progressing with full rollout planned for 2026. Implementation date – 1-8-26
Themes and Trends of Complaints Our review has found that there has been no reduction in the themes of complaints despite a focus on turnaround times. Complaints should lead to action that resolves their underlying cause however we have not seen a reduction that reflects this by operational leads. The top five themes as classified by management are noted as: • Clinical treatment/Assessment. • Communication Issues (including Language). • Attitude and Behaviour. • Medication. • Appointments.	Following the sustained improvement on the timeliness of complaint responses the next focus will be to support actions of change to address identified themes and trends. This will align with the introduction of the new NHS Concerns, Complaints and Redress Arrangements – Listening to People.	A thematic review will be undertaken on specific themes, which will provide insight and areas of poor performance, to which targeted improvement and support will be provided and evidence to be provided into the strategic patient and carer experience group (PCEG) and Organisational learning forum (OLF) to identify root causes. The PALS service is currently under consideration for redesign which will allow verification and reporting of actions taken in relation to learning and improvement. Implementation date – 1-4-26



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Patient Experience

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
The organisation collects patient experience feedback through various channels, however there is limited evidence to demonstrate that feedback is currently being used to drive improvement through the Health Board per the Welsh Government People's Experience Framework self-assessment tool (page 26 Using People's Feedback to Drive Quality Improvement and Learning). It is noted that the Patient Experience Team recognise this issue and are working towards initiatives to address this. This should include ensuring that the Patient Experience Team are sighted on relevant patient experience feedback / information included in external reports / reviews.	Work is underway to embed the People's Experience Framework. This will be fully mobilised alongside the Introduction of the Listening to People framework and the changes to the Corporate Teams.	• Conduct a baseline audit of current feedback mechanisms and usage. • Engage with stakeholders to co-design a feedback-to-action pathway. • Pilot the learning repository in selected services to test usability and impact. • Report progress to the Quality, Safety & Experience Committee on a quarterly basis Implementation date – 1-4-26



Corporate Risks / Board Assurance Risks

	OPEN DATE	TARGET DATE	RISK SCORE	CHANGE IN RISK SCORE	KEY ACTIONS TO REDUCE THIS RISK SCORE	BARRIERS TO IMPLEMENTATION / DELIVERY	RISK APPETITE
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes BAF Leads – EDON, EDOPW, EMD, EDAHP/HS Exec Lead: EDAHP/HS	20/10/24	01/04/2026	20	None	A number of controls are identified within the plans to manage the risk and reduce the likelihood / impact of the threat, this is including against any gaps in controls and are set out in the assurance document	• Lack of integrated patient care records impacting on care, planning and Reporting. • Improving real time patient data • Visibility of community mental health activity Recruitment and Retention challenges impacting on workforce including interim posts • Engagement and collaboration with physical health services • 'Foundations for the Future' programme maturity • Insufficient focus on health inequalities	Above tolerance



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Audit Committee

STATUTORY COMPLIANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	17 February 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Draft Status - Final Version will be Published
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	For Noting

Crynodeb Gweithredol Executive Summary

This report provides an update on the Health Board's statutory compliance position, covering internal and external audit activity, regulatory body reviews, policy management, and national inquiries. It highlights areas where progress has been made, alongside ongoing risks that require Executive oversight and timely action.

Internal Audit and Audit Wales recommendations continue to represent a significant compliance risk, with a number of high-priority items overdue their original implementation dates, and several '*unsatisfactory*' and '*limited*' assurance recommendations remain open. However, a number are being put forward for Audit Committee approval for closure.

Regulatory body reviews continue to be actively monitored. While improvement actions are progressing across Healthcare Inspectorate Wales (HIW) inspections and Care Inspectorate Wales (CIW) reviews, some areas remain outstanding and require continued attention from operational teams and Executive Team Members to reach closure.

Policy compliance remains a key risk. A number of policies and other written control documents are overdue a review, including those relating to patient safety. This requires prioritised action to ensure the Health Board maintains up-to-date and robust governance arrangements. Details are provided in Section 6 of Annex A.

National inquiry activity is expected to increase significantly during 2026. The UK Covid-19 Inquiry will publish multiple module reports, and the Health Board must ensure readiness to respond quickly to findings and recommendations. The Thirlwall Inquiry is also expected to report after Easter 2026, and preparations continue through established structures.

Overall, while there has been progress across several areas, statutory compliance remains an area of heightened risk. Timely Executive action is required to progress outstanding recommendations, strengthen policy compliance, and ensure readiness for forthcoming inquiry outputs.

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	28/01/2026	Noted

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

CIW	Care Inspectorate Wales
ECRS	Enhanced Community Residential Services
EPOG	Executive Policy Oversight Group
HIW	Healthcare Inspectorate Wales
IHC	Integrated Health Community
IP-EDG	Executive Delivery Integrated Performance Group
MDT	Multi-Disciplinary Team
QEDG	Executive Quality Delivery Group
QSE	Quality, Safety and Experience Committee
RAG	Regulatory Assurance Group
SALT	Speech and Language Therapy
WCDs	Written Control Documents

STATUTORY COMPLIANCE REPORT

1. Y SEFYLLFA SITUATION

- 1.1 This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. Y CEFNDIR BACKGROUND

- 2.1 The Health Board is required to comply with a wide range of statutory duties, regulatory requirements, and mandatory standards set out in legislation, statutory instruments, and directions issued by Welsh Ministers.
- 2.2 Statutory compliance requires the Health Board to:
- Act within its legal powers and duties as set out in primary legislation, including the *National Health Service (Wales) Act 2006* and associated regulations
 - Comply with Welsh Ministers' Directions, All-Wales policies, and statutory guidance issued under legislation
 - Meet regulatory requirements imposed by external regulators, including Healthcare Inspectorate Wales (HIW), Audit Wales, the Care Inspectorate Wales (CIW), and professional regulators
 - Ensure systems of governance, risk management, and internal control are effective in securing compliance with legal and regulatory obligations
 - Implement, maintain, and review policies and procedures that support compliance with legislation
 - Monitor compliance and provide assurance to the Board through reporting, audit, and review mechanisms
 - Respond appropriately to breaches of statutory requirements, including incident management, regulatory engagement, and implementation of improvement actions.
- 2.3 Statutory compliance is a collective responsibility, with the Board retaining ultimate accountability and senior leaders and managers responsible for implementation within their areas of responsibility.

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

The full Statutory Compliance Report is included in Annex A of this cover report.

- 3.1 The Audit Committee is asked to note the content of this cover Report and Annex A.
- 3.2 Internal Audit recommendations presented for Audit Committee closure are included in Section 4.2.2 of Annex A.
- 3.3 Audit Wales recommendations presented to the Audit Committee for final closure approval are detailed in Section 4.3.1 of Annex A.

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

- 4.1 The implementation of audit recommendations will contribute to the reduction of risks across a number of Health Board areas, therefore timely delivery of the necessary actions relating to those recommendations is imperative.
- 4.2 Having effective, up to date and accessible corporate policies, procedures and other written control documents promotes governance best practice, guide staff and minimise risks, therefore updating and reviewing these documents in a timely manner is imperative.

5. **ARGYMHELLION** **RECOMMENDATIONS**

- 5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:
 - **NODI/NOTE** the report
 - **CYMERADWYO/APPROVE** the closure of the Internal Audit recommendations, as per Section 4.2.2 of Annex A
 - **CYMERADWYO/APPROVE** the closure of the Audit Wales recommendations, as per Section 4.3.1 of Annex A.

ASESIAD / ASSESSMENT	
Cyswllt 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:	

<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 Enablers of Quality Data to Knowledge	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</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>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:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog 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?	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>		
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:	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 <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.	

Contents

1. INTRODUCTION	9
2. INTERNAL AUDIT	9
2.1 Internal Audit – new audit reports	9
2.2 Internal Audit – open ‘Unsatisfactory’ assurance recommendations	9
2.3 Internal Audit – open ‘Limited’ assurance recommendations.....	10
2.4 Internal Audit - open and overdue ‘high priority’ recommendations	12
3. AUDIT WALES	12
3.1 Audit Wales – new audit reports	12
3.2 Audit Wales – open recommendations	12
4. AUDIT SUMMARY.....	13
4.1 All recommendations.....	13
4.2 Internal Audit	13
4.2.1 Internal Audit – awaiting Executive closure approval	13
4.2.2 Internal Audit – for Audit Committee closure	13
4.3 Audit Wales	13
4.3.1 Audit Wales – for Audit Committee approval.....	14
4.4 Audit - Re-profiling of historic and unmanageable items.....	14
4.5 Realignment of audit recommendations.....	14
4.6 Contracted Patient Services: Quality and Safety Arrangements audit report	14
5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)	15
6. POLICY MANAGEMENT	18
6.1 Executive Policy Oversight Group policy approvals.....	18
6.2 High-risk overdue policies update	18
6.3 Overdue procedures and written control documents	19
6.4 Overdue policy-documents – by Executive	20
6.5 Overdue WCD-documents – by Executive.....	20
7. STATUTORY INQUIRIES.....	21
7.1 UK Covid-19 Inquiry	21
7.2 Thirlwall Inquiry	22
APPENDICES	23

ANNEX A

BETSI CADWALADR UNIVERSITY HEALTH BOARD STATUTORY COMPLIANCE REPORT

1. INTRODUCTION

This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. INTERNAL AUDIT

Internal Audit recommendations continue to present a material compliance risk. A significant number of **'unsatisfactory'**, **'limited'**, and **high-priority** recommendations remain open, with many overdue their original implementation dates and several overdue by more than six months.

Although some items have received Executive Committee approval, progress overall is constrained by **outstanding evidence**, and **requests for additional assurance** that remains unmet. These delays are preventing timely closure, and limiting the Health Board's ability to demonstrate effective governance.

2.1 Internal Audit – new audit reports

Table 1 below shows all the Internal Audit reports received up to 31st December 2025.

Reasonable	Community services
Limited	Learning – Regulatory Reporting
Reasonable	Complaints management
Limited	Contract management and procurement review – Corporate Directors

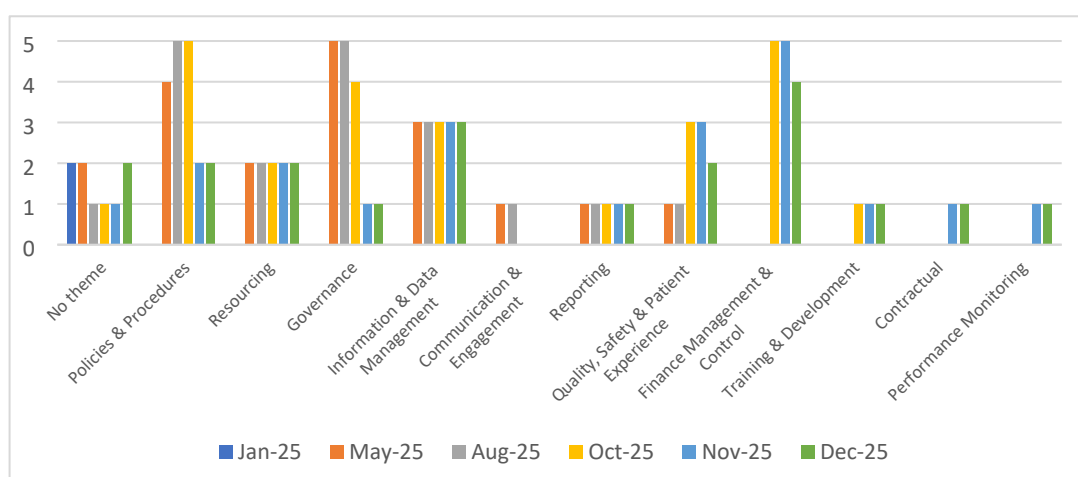
2.2 Internal Audit – open '*Unsatisfactory*' assurance recommendations

Table 2 summarises all open '*unsatisfactory*' assurance recommendations by Executive, highlighting those overdue against their original implementation date and those approved for closure by the Executive Team. It also shows the total number of high-priority recommendations overdue by more than six months as at 31st December 2025.

Executive Lead	'Unsatisfactory' assurance recs - open	Open 'unsatisfactory' assurance recs overdue original implementation date	High priority recs overdue original implementation date by 6 months or more	Total 'unsatisfactory' assurance recs approved for closure by Executive
Chief Executive	1	1	1	0
Executive Medical Director; Deputy Director of People	5	5	0	0
Executive Medical Director	7	3	0	0
Executive Director of Finance	5	5	0	1
Chief Operating Officer	2	1	0	1
Total	20	15	1	2

A copy of all open '*unsatisfactory*' assurance recommendations is included in Appendix 1.

Graph 1 below shows the open '*unsatisfactory*' recommendations per theme since January 2025.



2.3 Internal Audit – open '*Limited*' assurance recommendations

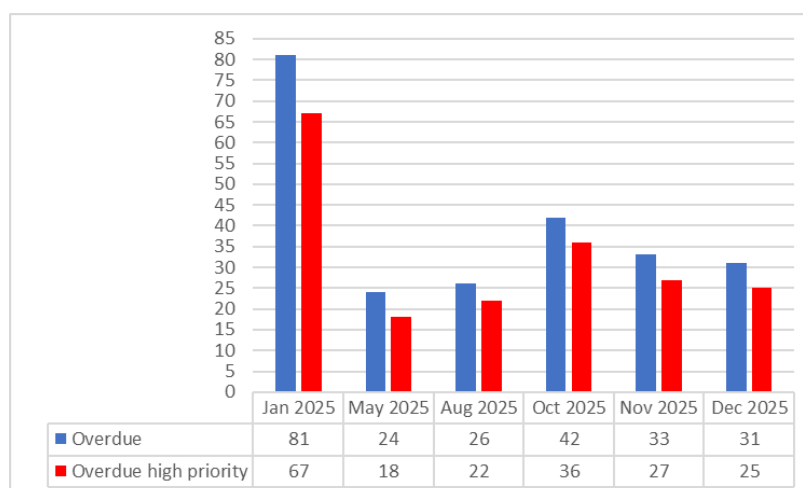
Table 3 summarises, by Executive, all open '*limited*' assurance recommendations as at 31st December 2025, including: the total number open, those overdue, high-priority items overdue by more than six months, and those approved for closure by the Executive Committee.

Executive Team Member	Total 'Limited' assurance recs - Open	Open 'Limited' assurance recs overdue original implementation date	High priority recs overdue original implementation date by 6 months or more	'Limited' assurance recs approved for closure by Executive Committee
Executive Director of Nursing and Midwifery	4	3	0	6
Chief Executive	5	2	0	0
Chief Operating Officer	3	1	0	11
Deputy Director of People	1	1	0	0
Director of Corporate Governance	10	2	0	0
Executive Director of Finance	9	9	5	0
Executive Medical Director	4	4	3	0
Executive Medical Director; Deputy Director of People	1	1	0	0
Chief Digital and Information Officer	2	0	0	0
Director of Partnerships, Engagement and Communications	2	2	0	1
Executive Director of Public Health	2	2	0	2
Director of Environment and Estates	4	4	2	1
Total	47	31	10	21

A copy of all open '*limited*' assurance recommendations is included in Appendix 2.

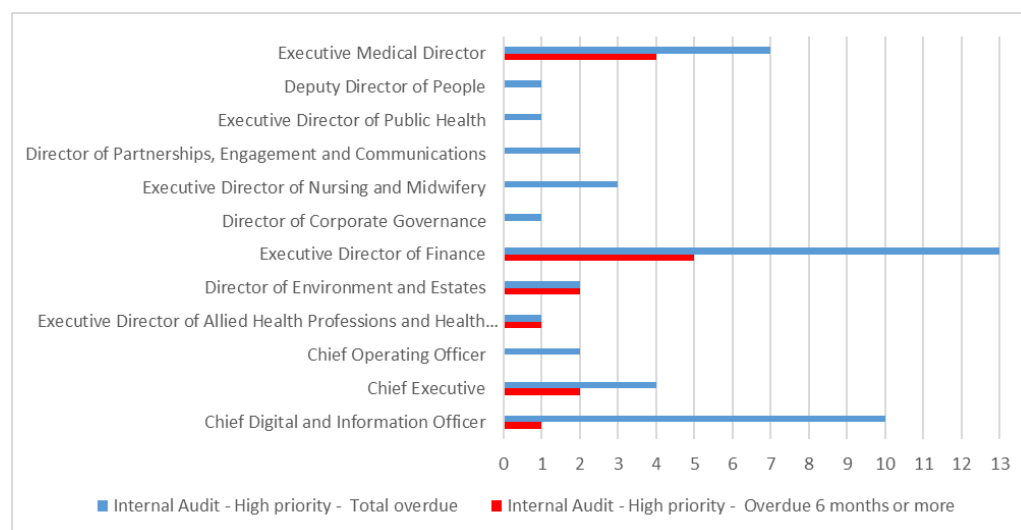
2.3.1 High priority '*limited*' recommendations

Graph 2 below shows all overdue '*limited*' assurance recommendations since January 2025, and of those overdue, the 'high priority' total.



2.4 Internal Audit - open and overdue 'high priority' recommendations

Graph 3 below provides details of all open 'high priority' Internal Audit recommendations overdue the original implementation, and the number overdue by 6 months or more (as at 31st December 2025), listed by lead Executive Team Member.



3. AUDIT WALES

3.1 Audit Wales – new audit reports

The 'Tackling the Planned Care Challenges' audit report has been published since the last update, and recommendations added to the tracker (correct as at 31st December 2025).

3.2 Audit Wales – open recommendations

Table 4 below shows the number of Audit Wales recommendations overdue their original implementation date by 6 months or more (as at 31st December 2025):

Report Title	Number overdue original implementation date - 6 months or more	Lead Executive Team Member
Structured Assessment 2022	1	Chief Digital and Information Officer
Structured Assessment 2023	2	Director of Corporate Governance
Structured Assessment 2024	1	Director of Corporate Governance
Review of Cost Savings Arrangements	2	Executive Director of Finance
Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2	Chief Operating Officer
Total	8	

The details of all the open Audit Wales recommendations are included in Appendix 3.

4. **AUDIT SUMMARY**

4.1 **All recommendations**

Table 5 below provides a summary of all recommendations, and position in the closure approval process.

	As at 14/03/2025	As at 24/04/2025	As at 29/07/2025	As at 29/07/2025	As at 02/10/2025	As at 06/02/2026
New Internal Audit recommendations	46	60	98	20	20	18
New Audit Wales recommendations	8	24	0	0	17	22
With Internal Audit for review	0	0	0	8	0	54
With Audit Wales for review	0	0	0	8	0	5

4.2 **Internal Audit**

4.2.1 **Internal Audit – awaiting Executive closure approval**

Table 7 provides the list of all internal audit recommendations put forward by the owner as implemented, but are outstanding lead Executive Team member approval.

Executive Lead	Awaiting approval by Executive
Executive Medical Director	1

Appendix 4 provides details of the recommendation awaiting Executive approval for closure.

4.2.2 **Internal Audit – for Audit Committee closure**

Appendix 5 provides details of the Internal Audit recommendations presented to the Audit Committee for closure approval. These are a combination of recommendations:

- that fall outside this review scope for Internal Audit review
- that have received approval for closure by Internal Audit, but now need final closure approval by the Audit Committee.

4.3 **Audit Wales**

4.3.1 **Audit Wales – for Audit Committee approval**

Appendix 6 provides details of the Audit Wales recommendations presented to the Audit Committee for closure approval.

4.4 **Audit - Re-profiling of historic and unmanageable items**

The Corporate Governance Directorate has not been made aware that there are any recommendations that need consideration as no longer relevant.

4.5 **Realignment of audit recommendations**

There has been no realignment of audit recommendations since the last report.

4.6 **Contracted Patient Services: Quality and Safety Arrangements audit report**

Discussions have taken place between the Executive Director of Finance, Executive Director of Nursing and Midwifery and Director of Corporate Governance to progress the findings from the Contracted Patient Services: Quality and Safety Arrangements audit report.

The Executive Director of Finance will provide a verbal update on progress at the Audit Committee.

5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)

5.1 HEALTHCARE INSPECTORATE WALES

5.1.1 Inspection – Ysbyty Gwynedd Emergency Department (14th-16th April 2025)

- **Status:** Overdue
- **Recommendations:** 28
- **Actions:** 66 total; 62 completed (94%)
- **Outstanding:** 4 actions remain
- **Closure Date:** Revised to January 2026.
- **Governance:** Continuous monitoring via Local Health Inspectorate Wales (HIW) Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

5.1.2 Inspection – Cemlyn Ward, Ysbyty Cefni (28th-29th July 2025)

- **Status:** In Progress
- **Recommendations:** 19
- **Actions:** 41 total; 31 completed (76%)
- **Closure Date:** 16 January 2026
- **Governance:** Progress monitored through T4 Programme Group, RAG, and EQDG.

5.1.3 Requests for Assurance

The Health Board responded to three requests for assurance from HIW concerning Clywedog Ward, the Acute Cardiac Unit (Integrate Health Community (IHC) East), and the Cardiac Physiology Unit (IHC Central). In each case, improvement actions were detailed, and HIW has not raised further queries on two of the three matters.

5.1.4 Concerns / Requests for Assurance

- **Clywedog Ward, Heddfan Unit, IHC East (November 2025)**
HIW have requested assurance following concerns received relating to cultural issues, potential delays in Speech and Language Therapy (SALT) and training provision.
- **Acute Cardiac Unit, IHC East (November 2025)**
Assurance request from HIW highlighted concerns around Covid-19 transmission, isolation/testing, exposure, and staff mask compliance. The Health Board responded with the action it is taking to address the issues. No further requests for assurance received from HIW.

- **Cardiac Physiology Unit, IHC Central (October 2025)**
Assurance request from HIW in relation to training , medical oversight, and culture. The Health Board has responded with the action it is taking to address the issues. HIW has raised no further queries following this response issued on 23rd October 2025.

5.2 **CARE INSPECTORATE WALES**

A Quality-of-Care Review for Enhanced Community Residential Services (ECRS) on 24th November 2025 found no immediate concerns and noted no areas for improvement.

A previous Quality of Care Review for ECRS on 4th July 2025 also found no immediate concerns but noted minor areas for improvement. The service is progressing well with its improvement plan, which is on track for closure in March 2026.

5.3 **QUALITY PEER REVIEWS**

The Quality Directorate provides governance oversight for peer reviews to ensure accountability and monitor improvement actions.

An exception-based Trauma Network Peer Review, identified gaps in BCUHB transfer documentation, inconsistent multi-disciplinary team (MDT) communication, and a need for clearer governance. An improvement plan is currently in development with the Health Board Trauma Network team/IHCs to address these findings.

5.4 **PUBLIC SERVICES OMBUDSMAN FOR WALES**

5.4.1 **Public Interest Report:**

One Public Interest Report has an outstanding action related to the Commissioning Assurance Framework. This is progressing through process. A revised deadline of 31st January 2026 has been agreed with the Ombudsman.

5.4.2 Performance Metrics (2024-25)

The Health Board has seen positive trends, including a reduction in complaints investigated by the Public Services Ombudsman for Wales (PSOW) (down from 81 to 64) needs periods of time, or months and those upheld (down from 41 to 19), alongside an increase in compliance with recommendations (up from 58% to 65%). These metrics demonstrate progress despite challenges, such as cases where agreed deadlines are changed by the Ombudsman or dependencies on other NHS bodies for information in cross-border cases.

5.4.3 Improvement Focus

Key areas for improvement include:

- Strengthening complaint handling and early resolution to reduce escalation.
- Embedding the Listening to People Framework (2026) to improve responsiveness and empathy.
- Building continuous learning from patient feedback, incidents, and Ombudsman recommendations.
- Integrating Ombudsman reporting into governance systems, with stronger tracking via the Quality Dashboard and escalation to Executive level.
- Enhancing Board oversight by embedding Ombudsman reporting into the QSE Committee from December 2025.
- Collaborating with other Welsh Health Boards to benchmark performance and maintaining proactive engagement with the Ombudsman's Office

6. POLICY MANAGEMENT

6.1 Executive Policy Oversight Group policy approvals

Table 8 below lists the policy reviewed and approved by the Executive Policy Oversight Group (EPOG) since the last update. Once approved, this policy will be published on BetsiNet by the Statutory Compliance Team, pending any actions from the Group being completed. The Group is chaired by the Director of Corporate Governance.

Policy Name and reference	Lead Executive Team Member
MHLD 0035 Home Treatment Team Operational Policy	Executive Director of Allied Health Professions & Health Science
COM02 Betsi Cadwaladr University Health Board (BCUHB) Operational Procedure for Responding to Representations from Llais, The Citizen Voice Body for Health and Social Care in Wales	Director of Partnerships, Engagement and Communication
For noting only, in line with the agreed BCUHB process around all-Wales/externally approved documents	
WP13 All Wales Flexible Working Policy	Executive Director of People and Organisational Development
WP16 NHS Wales Secondment Policy	Executive Director of People and Organisational Development

6.2 High-risk overdue policies update

The Audit Committee requested an update on overdue policies that posed the highest risk to the Health Board. All policies overdue their review date pose a risk to the Health Board, however, those relating to 'patient safety' were identified as those posing the highest risk as there is a potential direct impact on the safety of patients. The Statutory Compliance Team has undertaken an ongoing review and request for updates on progress around policies overdue a review.

Table 9 below provides details of the overdue policies relating to patient safety as at 12th January 2026.

Name	Review Date	Responsible Director
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2019	Chief Operating Officer
NHS Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).pdf	01/06/2020	Executive Medical Director
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	01/07/2020	Executive Director of Allied Health Professions and Health Science
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	01/03/2021	Executive Medical Director
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	01/05/2021	Executive Medical Director
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	01/09/2021	Executive Medical Director
MM02 - Injectable Medicines Policy.pdf	08/07/2022	Executive Medical Director
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	01/12/2022	Chief Operating Officer
MM01 - BCUHB Medicines Policy.pdf	31/12/2023	Executive Medical Director
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	15/01/2024	Executive Director of Allied Health Professions and Health Science
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	01/03/2024	Executive Director of Allied Health Professions and Health Science
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	01/08/2024	Chief Operating Officer
MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf	29/04/2025	Executive Director of Allied Health Professions and Health Science
RD02 - Policy for Research Involving Ionising & Non Ionising Radiation.pdf	25/05/2025	Executive Medical Director
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	31/08/2025	Executive Medical Director
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	01/09/2025	Executive Medical Director
NU33 - All Wales Thromboprophylaxis Policy.pdf	01/11/2025	Chief Operating Officer

Appendix 7 provides a full list of all overdue policies as at 12th January 2026, and progress updates provided up to that date, where provided.

6.3 Overdue procedures and written control documents

The Statutory Compliance Team continues to work with lead Executive Team Members to progress overdue procedures and other written control documents (WCDs). WCDs includes all procedures, guidelines, procedures, protocols, strategies and 'other' documents currently listed on the Policy Management System.

6.4 Overdue policy-documents – by Executive

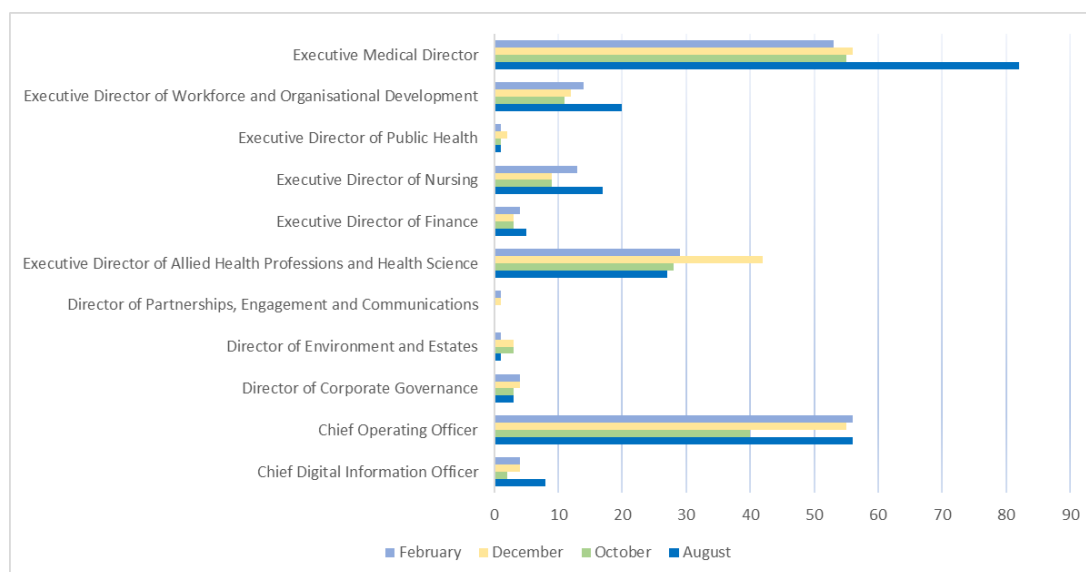
Table 10 below provides the total number of all overdue policies and WCDs, which include all-Wales documents.

	Policy Overdue	WCD Overdue
Chief Digital Information Officer	5	4
Chief Executive	0	
Chief Operating Officer	6	56
Director of Corporate Governance	2	4
Director of Environment and Estates	5	1
Director of Partnerships, Engagement and Communications	0	1
Executive Director of Allied Health Professions and Health Science	7	29
Executive Director of Finance	2	4
Executive Director of Nursing and Midwifery	2	13
Executive Director of Public Health	0	1
Executive Director of Transformation, Strategic Planning and Commissioning		
Executive Director of Workforce and Organisational Development	8	14
Executive Medical Director	17	53
	54	180

6.5 Overdue WCD-documents – by Executive

Graph 4 below provides a comparison of the number of overdue WCDs, by lead Executive Team Member, which include all-Wales documents.

Please note that the reference to August, October, December and February in the following graph refers to Audit Committee meetings dates.



7. STATUTORY INQUIRIES

7.1 UK Covid-19 Inquiry

The UK Covid-19 Inquiry has announced its plans for 2026. In what will be a busy year for the Inquiry, it will hold its final set of public hearings for its Impact on Society investigation (Module 10) from 16th February to 5th March 2026.

The Inquiry will also publish a further five reports covering Healthcare Systems (Module 3), Vaccines and Therapeutics (Module 4), Procurement (Module 5), the Care Sector (Module 6) and Test, Trace and Isolate (Module 7).

These reports will be published following thorough analysis of the evidence submitted to the Inquiry for each investigation. The Chair of the Inquiry will set out her findings and recommendations in the reports, with the expectation that all accepted recommendations be implemented without delay.

On 19th March 2026, the Inquiry will publish its Module 3 report on Healthcare Systems, followed by the publication of the Module 4 report on Vaccines and Therapeutics on 16th April 2026. These reports follow public hearings held in September, November 2024 and January 2025.

Summer 2026 will see the publication of the Module 5 report, examining Procurement. Towards the end of the year, reports will be published for Module 6, investigating the Care Sector and Module 7, investigating Test, Trace and Isolate.

The remaining three reports will be published in the first half of 2027. These are:

a) **Module 8 - Children and Young People**

Module 8 hearings took place from 29th September–23rd October 2025.

b) **Module 9 – Economic response**

Public hearings for the investigation into the economic response to the pandemic began on 24th November 2025, and continued until 18th December 2025.

c) **Module 10 – Impact on society**

Public hearings for the investigation into the impact of the pandemic on society (Module 10) are due to take place in early 2026. When these hearings conclude, the focus of our Chair, Baroness Hallett, will be on reporting her remaining findings and recommendations as quickly as possible. It is expected that regular publication of reports will take place from spring 2026 with the majority published before the end of that year.

7.2 **Thirlwall Inquiry**

The Inquiry has written to Core Participants with an update on the timetable for the final report. Work on the report is ongoing, and publication is scheduled for after Easter 2026.

APPENDICES

APPENDIX 1 – INTERNAL AUDIT – OPEN ‘*UNSATISFACTORY*’ ASSURANCE RECOMMENDATIONS

APPENDIX 2 – INTERNAL AUDIT – OPEN ‘*LIMITED*’ ASSURANCE RECOMMENDATIONS

APPENDIX 3 – AUDIT WALES – OPEN RECOMMENDATIONS

APPENDIX 4 – INTERNAL AUDIT – RECOMMENDATIONS AWAITING EXECUTIVE CLOSURE APPROVAL

APPENDIX 5 – INTERNAL AUDIT – FOR AUDIT COMMITTEE CLOSURE APPROVAL

APPENDIX 6 – AUDIT WALES – FOR AUDIT COMMITTEE CLOSURE APPROVAL

APPENDIX 7 – POLICY MANAGEMENT – ALL OVERDUE POLICIES

OPEN 'UNSATISFACTORY' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementat ion date	Revised implementati on date	Number of Revisions	Update at 15/12/2025
0457	Operating Model	2024	Unsatisfactory	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	2. The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	2. As part of the organisational structure review, all accountability frameworks will be reviewed	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	2	No further update at this stage
1431	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.1 Medical Resourcing Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			A national policy and procedure for job planning has been agreed across Wales has been developed. Management and the LNC have reviewed this documentation and developed a clearer job planning protocol. This is due to be submitted to the LNC in January for approval and then a training and development programme will be established for clinical leaders and consultants.
1432	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.2 Medical Resourcing Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Once a new job planning policy and protocol is implemented, the number of job plans will and robustness of plans can be reviewed by OMD. Processes have been implemented to ensure that any job plan over 13PA has Medical Director approval for all new recruitment.
1435	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.1 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are	4.1 The system is web based so accessible anywhere and backup by Allocate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			BC plans have been reviewed in the people directorate and have been uploaded onto the BC tracker.
1436	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.2 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			A medical advisory function has now been established to bring further controls over plans and reconciliation. This function commenced from 01 October 2025.
1437	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.3 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			The people services team has implemented as much automation as possible to the system from ESR. However, there will still need to be manual input in some fields.

1551	Waiting List Initiative payments – IHC Centre	2025	Unsatisfactory	High	Objective 1: There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales.	1. Health Board Procedure The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff. We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515).	1. The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures. The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025	31/12/2025	1	This has been to OLT on the 28 October 2025, a meeting is to be arranged with the Executive MD, and this is being requested.
1570	Effective Governance - Cancer Services	2025	Unsatisfactory	High	Objective 3: The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	3. Clinical Audit Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26.	3. Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits. Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer. Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity. The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a substantive	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Clinical Strategy working group established and meeting weekly. Principles agreed and details being worked upon with aim to complete by end of March 2026. Oncology consultant job planning to commence from February 2026 with a focus on developing a clinical audit plan. Action on track for completion by deadline
1643	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 2: Project Performance	1. Procurement/Contract Strategy The project is being delivered utilising the JCT Standard Building Contract Without Quantities (2016). To date, the project has experienced significant performance issues, including delays, cost uncertainty, and difficulties in managing scope changes. These issues suggest that the form of contract may not be optimally aligned with the complexity and risk profile of the project. It is acknowledged that as part of original efforts to expedite the project to meet WG expectations it was decided that a JCT Contract without quantities would offer the best solution. The UHB may wish to undertake a formal review of its choice of contract strategy, specifically the suitability of the JCT Standard Building Contract Without Quantities (2016) for complex or evolving project environments. The review could assess whether an alternative form would provide better mechanisms for collaborative risk management, cost control, and programme certainty. The findings of this (and a wider evaluation of the project delivery would help mitigate these issues on future projects.	1. Each specific project within the annual Capital Programme shall be subject to a documented delivery strategy including the project specifics, phasing/decant plan, design strategy, procurement strategy, risk management strategy and shall be used as part of the contract selection criteria. The strategy for each project shall be presented to the Director of Environment and Estates for agreement prior to inclusion in the business case. This shall be part of the business case (Commercial Case) and shall document the contract adopted and the benefits and risks. The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings. <i>LOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.</i>	Russell Caldicott, Executive Director of Finance	31/10/2025			There is little opportunity to amend LOH in this regard now other than to actively use and enforce the contract terms. Whilst there remains a narrative that the JCT contractors design shall never be used by BCU again, this should not be the case. The form of contract should reflect the specific requirements of the project and SFI's and be included in the procurement strategy at the outset.
1644	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 2: Project Performance	2. Design delays Prior to going out to tender the UHB engaged a design team to achieve a RIBA Stage 4 level of design to ensure that wherever possible the contractor had sufficient design information during the tender stage to provide a full cost assessment. However noting the nature of the project, it was agreed that a level of further design work would be required by the successful contractor for the project to proceed. When the Works packages were assigned to the successful bidders the UHB design team were not novated across to the appointed contractor who wished to engage their own Mechanical & Engineering (M&E) design team. It is understood however that the UHB has maintained the services of their design team to provide support during the project. The Project to date has suffered from significant delays, some of which are attributable to design considerations, of note are the following extracts from update reports (Highlight reports and Project Manager's Reports for February and March 2025), showing a timeline of design delay issues: • The WS4 (design) submission received in February (2025) was incomplete. The contractor was informed of this in February, following a formal notification sent in January. • Design review held on 14 February; further submissions received on 17 and 19 February. Comments from the client and design team issued on 5 March; contractor comments received on 7 March and addressed by 10 March.	2. The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include: 1. Who undertake what design packages. 2. The design stages. 3. Design transfer/novation arrangements. 4. Design warranty or professional indemnity arrangements. 5. Roles and responsibilities under the contract and for the retained team. 6. Coordination and technical submission arrangements and design variance obligations/restrictions. The criteria may vary according to the specific project. Each project shall, at the earliest opportunity, include an integrated programme for all stages to post-occupation evaluation to the design strategy. The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation. <i>LOH: Continue to report and review monthly with escalations and mitigations.</i>	Russell Caldicott, Executive Director of Finance	31/08/2025			At present, the BCU external Project Managers have circulated the most recent contractor design information which has been reviewed and returned to the contractor as Status B - the first time that the formal JCT design review process has been employed. The contractor has sent some information to respond to the comments, but this has been to a low quality and not materially addressed comments. Engagement continues.

1652	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 6: Site Progress	10. Inspecting Regime RIBA Stage 5 The RIBA 2020 Plan of Work notes that “It is crucial that it is clear who is to inspect Construction Quality, so that the client can be sure the building will be delivered in line with the requirements of the Building Contract”. As this is a JCT contract, the organisation opted to fulfil the traditional Clerk of Works function using internal staff. Two specialist roles were assigned to cover Electrical and Mechanical & Engineering aspects of the project. However, it was noted that there is an assurance gap relating to the inspection of the general construction elements of the build. The RIBA Plan of Work 2020 recommends <i>that inspections should be carried out by individuals with experience in similar construction technologies</i>. The absence of dedicated oversight in this area raises concerns regarding the adequacy of assurance over	10. When a NEC suite contract is used, there is a contractual requirement for the use of Supervisors to routinely inspect and report upon the works. When a JCT suite contract is used, BCUHB shall appoint equivalent appointments for Clerk of Works to inspect and report upon the works. Both approaches provide assurance relating to the works with the reports passed to the Project Manager for inclusion in the monthly progress report. <i>LOH: The appointment of a building Clerk of Works is unlikely to benefit the scheme at this stage. However, BCUHB to request the architect undertakes site inspections and reports on compliance with their design. M&E inspections to continue.</i>	Russell Caldicott, Executive Director of Finance	30/09/2025			Site inspections are being undertaken by external consultants including the architect and services engineers. These reports are collated by our external Project Managers for issue to the main contractor. It would not be normal for all reports to be issued to the Project Board.
1653	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	Medium	Objective 6: Site Progress	11. Inspection restrictions It was noted from conversations with the respective Clerks of Works that they did not enjoy unfettered access to the site as they were not in possession of the appropriate Construction Site Safety Certification (CSCS) to allow unaccompanied visits. As a result, visits now depend on the availability of the main contractor, with Clerk of Works personnel requiring accompaniment by main contractor employees.	11. BCUHB staff responsible for site visits shall be required to attain the appropriate CSCS accreditation commensurate with their role. This shall be deemed an essential qualification to the satisfactory execution of their duties. <i>LOH: Staff to be requested to obtain CSCS accreditation if their role requires it.</i>	Russell Caldicott, Executive Director of Finance	31/12/2025			BCU staff being supported in securing CSCS cards. In the meantime, site visits will remain in accordance with the Contractor's site rules and accompanied if necessary. At present there are no reports of visits being refused due to CSCS cards.
1654	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 6: Site Progress	12. Commissioning Programme The Clerks of Works noted that they had concerns over the programme of commissioning, this view is supported by the latest Project Manager’s report which notes under the key risk/issues section that A detailed commissioning programme needs to be developed with input from the BCUHB / NWSSP teams. This needs to demonstrate the interdependency between both the <i>Main and Enabling Works programmes</i>. The report provides further background as to the issues and engagement to date. A formal commissioning programme was requested in Contract Administrator’s Instruction (CAI) 113 issued on 13th January 2025. The first iteration that was received on 11th February did not provide sufficient detail and this was notified to the contractor, along with examples of commissioning programmes from other projects, to demonstrate the required level of detail. A revised commissioning programme is awaited. Whilst noting the above concerns as raised about commissioning it is understood that the UHB are seeking to condense the commissioning process to achieve a handover of patient areas ahead of the revised completion date. Given difficulties to date this would require careful consideration and planning, with potential risks assessed and included within the Project Risk register with potential costings for any mitigation required.	12. At the outset of the project adequate time shall be allowed for commissioning, witnessing and validation according to the specific requirements of the project including the appointment of a Commissioning Manager. <i>LOH: A commissioning manager has been appointed and integrated programme for agreement and adoption by stakeholders is being developed.</i>	Russell Caldicott, Executive Director of Finance	31/10/2025			The commissioning programme is a function of the works programme (including snagging), witnessing and validation programme and clinical commissioning programme each with a range of stakeholders. There remains no fully integrated and agreed programme leading to the first patient date and this is for a number of reasons resting with a number of parties. Example issues include the main contractor not committing to dates for certain tasks and BCU team requesting 'block' periods for tasks. The contractor has appointed a commissioning manager and dialogue remains ongoing and the DoE&E is engaging directly with stakeholders.

1668	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	1. Health Board Policy (<i>finding in original audit report</i>) The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process. FOLLOW-UP AUDIT REPORT FINDING: The Health Board does not have an agreed Policy/Standard Operating Procedure in place to support management, and consultants fulfil expected compliance with the nationally agreed Consultant Contract. This remains a significant gap in internal control. We are advised that the Health Board has not progressed with its own draft policy/procedure as it waited for nationally developed best practice guidance which has not materialised. With no policy or standard operating procedure in place, we recognise the decision not to develop a Health Board wide training needs analysis. We have seen evidence where the Job Planning Specialist	1. REVISED ACTION IN FOLLOW-UP REPORT: The final draft of the BCU job planning policy (JPP) (co-authored with LNC / BMA) is to be discussed by Executive Medical Director at JLNC meeting on 14 October 2025. It is anticipated that final approval of the JPP will be secured by December 2025. However, this is a re-iteration of current principles and processes and thus implementation can continue as this goes through final sign off. A training needs analysis has identified 3 core staff groups, with trajectory for completion of training: 1. All medical staff in leadership position with operational responsibility will require training against the JPP. Training to be completed for all within 2 months of JPP approval. Training will be delivered as a series of roadshows, which are planned to be delivered jointly by senior medical leaders and LNC colleagues. 2. Operational staff who will be supporting team and individual job plan meetings. These staff will require both training re JPP and the use of Allocate system. Completion of training re JPP within 2 months of sign off. Allocate training 6 months from date of submission of this paper i.e., March 2026 3. Medical staff who are required to have annual job plan in place. Training for this staff group will be managed via 2 processes (a) alongside the medical leadership team, anticipated compliance with training will be 60% within 2 months of JPP approval (b) linked to the date of their next job plan for those who have not attended initial ‘roadshow’ training events. Compliance of above 95% training would be achieved within 1 year of JPP approval dependant on distribution of individual job planning meeting dates.	Clara Day, Executive Medical Director	31/05/2026			All 1st and 2nd signoffs have now been standardised across the majority of job plans, ensuring there is an operational manager with budget responsibility and clinical lead/director as part of the signoff process. . This has allowed a training plan to be put into place, commencing early January 2026, offering face to face sessions on all three sites. The initial training will be offered to all signoffs with a TNA used as evidence as training requirements. The training will then continue to doctors and will be offered moving forward on a regular basis with the addition of online sessions been made available.
1669	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	3 Ejob Plan First and second sign-off (<i>finding in original audit report</i>) Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system. FOLLOW-UP AUDIT REPORT FINDING: There has been no formal review of first and second sign off within the Ejob Plan system. We were advised that Women’s Services have undertaken a review of their sign off details but have not corroborated this. Our review of the information has again identified test and generic details in the system that compromises data quality. Only the training module should be used for test data to preserve the integrity of the live system	3 REVISED ACTION IN FOLLOW-UP REPORT: Process for sign off included in policy, including timeframes for sign off at each stage. The training programs will ensure staff are aware of the process and time to sign off for each stage. A previous ‘distant’ sign off process has been approved by Local Negotiating Committee (LNC) and will continue within the revised JPP. However, Allocate does not currently facilitate 'distant' sign off. Health Medics team in discussion to ensure this is possible and that any test data is removed from live system. We currently have not received a timeframe for an upgrade of Allocate to facilitate this process. If Allocate are unable to provide the Health Board will need to find a ‘work around’ which would be in place within 6 months i.e., April 2026.	Clara Day, Executive Medical Director	30/04/2026			Roles & Responsibility SOP has been presented to the V&S Job Planning sub group December 10th, still awaiting feedback before approval and implementation.
1670	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner	5. Job Plan annual review (<i>finding in original audit report</i>) Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data. The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work. FOLLOW-UP AUDIT REPORT FINDING: Our review of Health Board data as of 1 September 2025 showed overall compliance of 42% (Image 1 above) where job plans have been agreed and signed off. We have been advised that review dates have not been amended to reflect the individual’s incremental date. It remains unclear how the Health Board will meet the 90% target of in-date job plans by 30 September 2025, set by Welsh Government	5 REVISED ACTION IN FOLLOW-UP REPORT: All Wales medical T&Cs advise that all relevant staff should have an in date and signed off job plan at least annually, with updated job plans if there is any significant change to the doctors working pattern or responsibility. This is clearly outlined in the draft policy. It will mean that job plans may not align to the doctor’s incremental date. It is also anticipated that any change in operational structure recommended by Foundations for the Future cultural review may impact a number of individual job plan reviews. Monitoring via Power BI in place and allows for drill down by team (but not to individual staff level). The Health Board acknowledges that the target of 90% by September 2025 has not been met. This is primarily due to the delay with agreeing a revised JPP. The proposed trajectory for compliance is 50% end Q3, 75% end Q4, >90% by end Q1. This trajectory will be signed off at the Medical Workforce Group 15 October 2025 Monitoring of compliance would be as above, via local processes and at HB level at Medical Workforce Group and People and Culture Committee.	Clara Day, Executive Medical Director	30/10/2025			Awaiting the Job Planning Protocol/Policy

1671	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner	6. Directorate/Specialty objectives are explicit (<i>finding in original audit report</i>) There is a generic statement within the Service Outcomes section of job plans “To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction”, (sic). The Service Outcomes section overall was either incomplete or noted “During job plan discussions need to review this”. From our review, we are unclear how management are approving job plans without expected service objectives. We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system. FOLLOW-UP AUDIT REPORT FINDING: We reviewed a sample of one job plan from the three Integrated Health Communities and the four pan North Wales clinical directorates. We found four (57%) were in date and current, however none had any directorate or specialty service objectives recorded.	6 REVISED ACTION IN FOLLOW-UP REPORT: The draft JPP outlines importance of service demand / capacity discussion prior to an individual job plan timetabling meeting. This will identify service priorities to align at job plan meeting. Individuals PDP from appraisals will inform service and personal priorities and objective for the coming year. The need for service priorities to be clearly articulated and aligned within individual job plans will be a core expectation for the training program and roadshows. Compliance with this element will need to be monitored via a quality assurance process which is beyond current capability of PowerBI monitoring. A sustainable automated solution will be in place within 6 months if DDaT colleagues have the capacity to prioritise this work It is anticipated that implementation of any operational structure following Foundations for the Future review may impact on a need to review service priorities and alignments.	Clara Day, Executive Medical Director	30/04/2026			Compliance report updated twice a week, and specialty managers and clinical managers are emailed the link to report
1672	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 4: Completed job plans reconcile to system records and session payments are correct	8. Regular review of payments to agreed job plan commitments (<i>finding in original audit report</i>) We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan. FOLLOW-UP AUDIT REPORT FINDING: The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this finding.	8 REVISED ACTION IN FOLLOW-UP REPORT: Allocate is now linked to ESR to ensure sessions agreed reflect payment. An SOP to ensure implemented will be linked to policy and will be in place by December 2025.	Clara Day, Executive Medical Director	31/12/2025			The People and Culture Committee in December received an update report in relation to consultant job planning, as it had been agreed by LNC that a new protocol could be implemented that goes beyond the All Wales job planning policy. The protocol will be agreed in the Jan 26 LNC, and this has been supported well by the BMA. This will allow the Health Board to have clear job plans, to the review against the dashboard. Therefore, in Q4 as revised job plans commence reporting will be implemented by POD and OMD to identify any variation and payments outside of job plan.

1673	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	10. Medical and Dental Job Plan reporting (<i>finding in original audit report</i>) There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance. FOLLOW-UP AUDIT REPORT FINDING: The OMD Job Planning team send out a monthly Job Planning Compliance email that includes a link for the job planning dashboard to a pre-determined circulation. We are unclear whether this circulation captures all relevant leads with responsibility/accountability for job plan compliance. We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women’s Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services. We noted limited assurance reporting at a local level within IHC West on job planning. The West IHC Medical Director (Chair of the MWG) provided evidence of follow-up compliance with job plan completion to West operational leads. Women’s Services hold monthly Centre, East and West	10 REVISED ACTION IN FOLLOW-UP REPORT: Monthly compliance figures are circulated to operational teams and the divisional and IHC medical leaders. It is tracked at Medical Workforce Group at Health Board Level. A compliance escalation and dissemination pathway will be in presented for sign off at November’s Medical Workforce Group to ensure clarity on information sharing and scrutiny. An assurance mechanism will be in place by the end of Quarter 4 Real time data is accessible via Allocate. How to access will form part of the Allocate ‘how to’ training.	Clara Day, Executive Medical Director	31/03/2026			As per 1672, job planning is reported into People and Culture in the wider operational performance pack, and is available as a Business Intelligence report. Work continues to automate as much as possible and this will be finalised in Q4.
1674	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	11. Medical Workforce Group & People & Culture Executive Delivery Group (EDG) (<i>finding in original audit report</i>) The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it “...will receive regular reports (on job plans) as per its Cycle of Business” but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board. FOLLOW-UP AUDIT REPORT FINDING: There is no evident reporting on consultant job plan performance to the Health Board’s People and Culture Committee through the People Operations Report. We note a verbal update was provided to the Committee by the Interim Executive Medical Director at the 14 August 2025 meeting (Agenda Item PC25/82). The People & Culture Executive Delivery Group is still yet to be re-established. Consequently, assurance reporting from the Medical Workforce Group is not subject to any scrutiny or assurance to the Executive Committee and/or the Health Board People &	11 REVISED ACTION IN FOLLOW-UP REPORT: Medical Workforce Group (MWG) is now chaired by an experienced medical leader who has developed Health Board Job Planning Policy in collaboration with LNC. It is the place where relevant care groups are held to account and where implementation of JP policy and relevant procedures will be monitored. MWG will report to People and Culture Executive Delivery Group and thus to People and Culture Committee	Clara Day, Executive Medical Director	31/10/2025			A People and Culture EDG will be established from January 2026 and information contained in the People Operations performance pack that is submitted already to People and Culture Committee will be scrutinised to support performance management. As noted there is a new All Wales Policy and local protocol that will be approved in the LNC.

OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementat ion date	Revised implementati on date	Number of Revisions	Update at 15/12/2025
0491	Health and Safety - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: “the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007”.	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	Stuart Keen, Director of Environment and Estates	01/09/2024			Quote received and the price for the delivery of the one-day HSE Certificate in Health and Safety Leadership Excellence training course at onsite in North Wales would be £9,800. This is for up to a maximum of 15 delegates and the price valid until 31 March 2026. Stuart Keen notified. Further discussion needed to determine way forward.
0493	Health and Safety - 2024	2024	Limited	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	Stuart Keen, Director of Environment and Estates	30/04/2024			Cohort 1 is now complete and paper presented to People and Culture Committee on 04/12/2025, which was received with positive feedback. Document shared as evidence. Cohort 2 returns have now closed and responses are being collated and Health and Safety Reviews are being scheduled. Engagement of DDaT been requested to support turning an intensive manual collation task into a slicker streamlined technology solution for 2026.
1341	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 ‘Firecode – Managing healthcare fire safety’, and Welsh Assembly Government NHS Wales Fire Safety	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Stuart Keen, Director of Environment and Estates	20/03/2025	16/02/2026	1	Fire Policy has been updated and will be approved at the following groups: Fire Safety Management meeting on 18th December 2025. Due to be presented at Occupational Health and Safety meeting on 16th February 2026
1343	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM o5-03 Part A.	Stuart Keen, Director of Environment and Estates	20/03/2025	01/09/2026	1	The review of the Fire Safety Training has been delayed until the second quarter of 2026/2027 due to awaiting publication of the revised WHTM05-03 Part A which it is hoped will be released in June 2026.
1445	Consultant Job Planning	2024	Limited	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct	9. Additional sessions undertaken outside of the substantive post We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive	9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			A new job planning policy will be agreed at the next LNC. This is supported by the BMA and will allow clarity over the number of PA's to be clear what is in scope of job plan and not. The next LNC is in January 2026, and an implementation plan will be developed.
1524	Clinical Audit - 2025	2025	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	Clara Day, Executive Medical Director	01/04/2025	30/06/2025	1	The second quarterly audit, conducted in October, indicates an improvement in the number of email escalations saved to the project folders. These escalation have started to be recorded within AMaT (see attached screenshots)
1525	Clinical Audit - 2025	2025	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	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	01/04/2025	30/06/2025	1	Escalation Process agreed at November’s CENAG meeting (Attached). Tier 1 action status to be included in Monthly Escalation Report from January 2026 and Q4 report

1526	Clinical Audit - 2025	2025	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	01/04/2025	30/06/2025	1	Learning from Tier 1 audits is captured on SAoC and the information from these forms are being categorised to identify any themes across the projects, this work is ongoing as the completed forms come in. The first request for a Tier 2 progress update will be issued in December, with findings to report in Q3 report in January. For projects that have completed, an SAoC assessment form will be sent. This form is similar to the one used for Tier 1s and captures learning and details of where they have been shared
1527	Clinical Audit - 2025	2025	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	01/04/2025	30/06/2025	1	Process continues and the number of open and overdue projects continues to reduce – (2024/25 activity) As of 31st March 2025, position was Open: - 72.9% (n=326) Overdue: - 56.6% (n=253) As of 20th Nov, 717 emails have been sent and the position for 2024/25 projects stands at: Open: - 13.9 (n=62) - down by 59.1% (n=264) Overdue: - 5.8% (n=26) - down by 50.8% (n=227) (2025/26 activity) As of 20th Nov, 224 emails have been sent and the position for 2025/26 projects stands at: Open: - 62% (n=168) Overdue: - 4.4% (n=12)
1534	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	1. Process Management	1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider.	Russell Caldicott, Executive Director of Finance	30/06/2025			Work has been progressing with a report due to go to January's board. Paper to be shared following the meeting.
1535	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	2. Contractual Obligations	2.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	Russell Caldicott, Executive Director of Finance	30/06/2025			Work has been progressing with a report due to go to January's board. Paper to be shared following the meeting.
1536	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements.	Russell Caldicott, Executive Director of Finance	30/06/2025			Review of contracts has started with work underway and a report being finalised for Jan board
1537	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.2: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required.	Russell Caldicott, Executive Director of Finance	30/06/2025			Work has been progressing with a report due to go to January's board. Paper to be shared following the meeting.
1538	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	4. Board Assurance	4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.	Russell Caldicott, Executive Director of Finance	30/06/2025			Update to be shared within the January 2026 Board report.

1558	Partnerships, Engagement and Communication	2025	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.	3.1 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~~	3.1 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: 1. Develop and implement a standard operating procedure (SOP) that outlines: • The Health Board’s expectations for engagement. • Required steps and responsibilities at each stage of the process. • Links to national guidance (e.g. WG guidance on service change). • Monitoring, assurance, and reporting requirements.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/01/2026	2	The revised toolkit was due to be discussed/endorsed at the December meeting of the SPSC Group but that meeting has been stood down. It is now on the agenda for the January meeting. New revised deadline of end of January 2026.
1561	Partnerships, Engagement and Communication	2025	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.	3.4 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~~	3.4 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: 4. Restore access to all key documents referenced: • Upload the Welsh Government Guidance on Service Change and the Key Lines of Enquiry Framework to BetsiNet. • Ensure all links are checked quarterly for functionality.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/12/2025	1	The revised toolkit was due to be discussed/endorsed at the December meeting of the SPSC Group but that meeting has been stood down. It is now on the agenda for the January meeting. New revised deadline of end of January 2026.
1569	Effective Governance - Cancer Services	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	2. 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.	2. The division took further actions in respect of grip and control of expenditure, with cost reductions & control actions aligned to the control total target issued by the health board being met and exceeded. Further action re delivery of CRES savings resulting achieving an over recovery of targets of £2k. However, it is recognised that a final £1m deficit remains against budget allocated and therefore non-compliant with requirements of Standing Financial Instruction 5.2.2 The overspend is represented by Drug related expenditure and commissioning contracts aligned to demonstratable growth. These issues have been escalated & reported through the health board and the various committees such as Execs & PFIG. Actions • An Oncology business case has been presented with final approval at board pending May 25 to secure recurrent budget. A further business case is ongoing to address further cost pressures linked to demand, activity, quality & governance pan BCU. • Ensure working focus groups such as SACT improvement etc are documented as reports for information or minuted through attendance at PFIG or SLT to demonstrate ongoing improvement for patient safety, quality, efficiencies and finance.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Monthly PFIG meetings continue with multi-professional oversight of spend and review of any additional funding requests. Weekly establishment control meeting with DGM, HoN, finance and people services to review all roles at DMT stage – only roles that are funded and considered essential are approved. All budget holders meet regularly with finance partners to ensure budgets are managed. Regular savings meetings have been convened to ensure attainment of savings target. Recurrent budget business case approved May 25. No further business cases to be presented until oncology clinical strategy agreed. Progress of focussed working groups such as SACT Operational & Improvement Group are documented in SLT or PFIG. The predicted overspend has reduced following additional budget for medicines and external contracting. Action on track for completion by deadline
1571	Effective Governance - Cancer Services	2025	Limited	High	Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	4. Open / Overdue Incidents As of March 2025, the service has 195 open incidents, with 154 of these overdue.	4. The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting.	Tehmeena Ajmal, Chief Operating Officer	31/10/2026			The number of open incidents as of 05/01/26 is 31 with 29 being overdue. All new incidents are discussed at the daily safety huddle and handlers assigned accordingly. Regular reminders are sent to all staff with overdue incidents and senior staff review details at weekly ICOG meetings. Concerns are closely managed and investigated immediately on receipt with none showing as overdue as of 05/01/26. Weekly ICOG meetings review all ongoing concerns, incidents, coroners, etc. A learning action plan has been developed and is regularly monitored and updated.
1573	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Medium	Matter Arising 1: Policy (Design)	1.2 The Head of Corporate Governance will issue a guidance note to all Managers as part of the development of a Corporate Governance Hub.	1.2 Management: • Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).	Pam Wenger, Director of Corporate Governance	30/09/2025			Governance Hub populated awaiting sign off for go live - will be continuously updated.

1580	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	SAME AS 2.1 (b) 5.1 (b) Management: • Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	SAME AS 2.1 (b) 5.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			Once these forms are live we will be able to evidence how effectively this is working in relation to an increase in declarations.
1581	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (a) To undertake specific improvement project looking at the processes at an IHC level in relation to Declaring Gifts and Hospitality . (March 2026)	6.1 (a) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	Pam Wenger, Director of Corporate Governance	31/03/2026			This was approved at the Audit Committee on 21 October 2025
1582	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (b) To establish Governance Network working with operational leads to support the implementation of this work .	6.1 (b) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director.	Pam Wenger, Director of Corporate Governance	31/03/2026			This was approved at the Audit Committee on 21 October 2025
1587	Grievance Management	2025	Limited	High	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.	2. Themes Whilst we are advised that grievance cases are reviewed and discussed locally and by the senior team within People Services, there is no documented information / data that identifies themes and trend of grievances across areas / the Health Board, and reports on these to an appropriate forum. This information should be reviewed to ensure appropriate actions are taken to minimise potential future grievances.	2. Quarterly review of closed R&R cases to collect data on the themes / trends, which will be reported via People and Culture meetings / Committee. Local People & OD teams will do this at the end of a case.	Jason Brannan, Deputy Director of People	31/08/2025	31/03/2026	1	Regular reports are now provided to the People and Culture Committee looking at themes and case numbers. A culture dashboard has been developed to bring multiple HR data sources together to analyse area performance.
1611	Effective Governance – Integrated Health Community - East	2025	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.	2. Accountability Letters A number of IHC East accountability letters for 2024/25 have not been signed, as required by Standing Financial Instructions. Out of a total of 89 letters, 73% (65) have been accepted, 23% (20) have had no response and 4% (4) are outstanding with a valid reason noted (not confirmed).	2. Sign accountability letters.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025			As per 01/11/25 64/79 agreements have been signed with four being queried with meetings in place to discuss concerns.

1618	Falls Management - Follow up	2025	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:	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	30/09/2025	31/03/2026	2	Therapists are present daily on the wards and attend board rounds. Pertinent information relating to mobility, transfer and function will be shared and communicated at Board Rounds to enable nursing staff to update the FBHMA assessment. Staff will also update WNCr with changes in function / mobility status. In addition, a wider action - led by AHP Directors is via the Strategic Falls Group to explore how all therapists across BCUHB can access and update the FBHMA consistently, ensuring a more integrated and standardised approach to falls risk management.
1622	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	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. Current status – Partially implemented 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	3.1(a) Action 2 - Training There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate – Head of Health & Safety (29th August 2025).	Angela Wood, Executive Director of Nursing and Midwifery	29/08/2025	31/03/2026	2	Progress on this action continues but has been slow due to the training for University students and the need for the whole manual handling team to support this intensive period which has been hampered by long term sickness and manager investment into the Developmental Advisor posts. Request to advertise a secondment to support the training awaiting authorisation.

1623	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	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. Current status – Partially implemented 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	3.1(a) Action 3 - Training Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher – Head of Health, Safety & Security -October 2025.	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025	31/03/2026	1	Meeting with the University was rescheduled for 12/11/2025. University can create a 16-hour accredited Train the Trainer Course (20 Level 4 credits) to support the upskilling of Manual Handling Champions. Calculated 8 cohorts of maximum 36 participants commencing April 2026, which would give us 288 places to be delivered between April 2026-March 2027, and then 2 or 3 cohorts of 36 per year thereafter to capture starters and leavers. Initial calculations for 16-hours x 8 cohorts would be around £6500 plus accreditation costs and an additional cost for some delivery at the Optic Centre, the University's satellite location in St Asaph, to capture staff based at Bangor. There is £750 of funding that BCUHB may be able to access and put towards this training. NOTE: This is only one element of the upskilling needed for Manual Handling Champions to deliver Manual Handling Refresher Training, they will also need to attend a Bespoke Manual Handling Training Course.
1632	Performance Management Framework and Reporting	2025	Limited	High	Objective 1: There is a governance structure with mechanisms for regular monitoring and escalation in place.	1. Governance Through the review of the Executive Delivery Group Minutes and reports received from two IHCs and MHL D we have not been able to confirm that Decision and Action Logs from substructure or Integrated Performance Scorecards feed into the Integrated Performance Executive Delivery Group or that performance translates down to Individual PADRs.	1. The Integrated Performance Framework to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure “ward to board” assurance reporting.	Russell Caldicott, Executive Director of Finance	30/09/2025			This is on hold until the structure of Foundations of the Future has been agreed at board level and is due to be finalised upon an approved board agreement.
1633	Performance Management Framework and Reporting	2025	Limited	High	Objective 2: There is evidence to support reported performance data and narrative.	2. Performance We have been unable to verify the source and rationale underpinning the identification and reporting of local performance metrics that are included in addition to the national measures. Consequently, we are unclear that the highest risk local matters are being reported for scrutiny and assurance.	2. Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target. Whilst outside of the NHS Wales performance framework it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS. The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.	Russell Caldicott, Executive Director of Finance	30/09/2025			Work continues to progress within this area with meetings taking place between the Head of Quality and performance teams to agree metrics.
1634	Performance Management Framework and Reporting	2025	Limited	High	Objective 3: Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service	3. Performance Accountability Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected. We were unable to confirm the outcomes of performance meetings as we did not receive any minutes/evidence of specific actions set to address the required improvement in performance.	3. Finding accepted. The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 with monthly meeting to be diarised during quarter 2 to run monthly from September onwards.	Russell Caldicott, Executive Director of Finance	30/09/2025			These meetings are due to be set up to run again in quarter four with updates to be shared across the executive team.

1655	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Limited	High	Objective 7: Equipping	13. Equipment budget The Project has an equipment budget of £3.4m and the outturn figure has remained as such despite, the work going on to reuse existing equipment where possible, it would be anticipated that this would feed into projected savings. However, the outturn has instead recently increased by £85k with no narrative explaining the reason for this increase. It is not clear at the present time what the eventual equipment expenditure will be, given the above, and issues over the ordering and supply of equipment, with possible financial and availability ramifications. The ongoing design issues (and absence of formal sign off) could also adversely impact on the final equipment schedules, budget and ultimately the	13. A genuine pre-estimate of equipment and costs shall be undertaken at key stages using the signed-off C-Sheets and Room Data Sheets and if not prepared by the Cost Manager, shall be reviewed by the CM. An audit of the equipment approved as required, equipment ordered and equipment delivered shall be undertaken as appropriate. <i>LOH: A review to validate the budget cost and equipment required, ordered and delivered was commenced in July 2025. A report will be presented at the August Board.</i>	Russell Caldicott, Executive Director of Finance	30/09/2025			At present, apx. 80% of the equipment has been ordered. The balance is mostly specific radiology equipment and is in the process of being ordered. A review of the equipment and costs has been undertaken an the budget and forecast outturn costs revised accordingly.
1658	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	High	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	3. Limited Plan Testing While some exercises have been conducted, most BCPs and incident plans have not been tested. Testing is not yet consistent across all departments. Women's Services exercises are delayed, and exercises for Emergency Departments are still in planning.	1) To draft an options appraisal on how we can best achieve the above. 2)To receive Executive sponsor sign off on the options appraisal, and take though the governance route of CCAG, Executive Committee and PPHP if required. 3)To then action and implement the agreed recommendation/option following governance reviews.	Jane Moore, Executive Director of Public Health	31/12/2025	31/03/2026	1	1) Options Appraisal paper is being finalised following comments from the CCAG 30/09/25, to present at CCAG 18/12/25. 2) On going as we await sign off of the paper by CCAG. 3) Once signed off, a programme will be drafted for goverannce, assurance and measuring, in readiness of implementation April 2026.
1660	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Medium	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	5. Outdated Policies and Procedures. Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.	All outstanding EPRR policies, templates, plans, policies and SOPs are agenda for approval/sign off at the next CCAG 30th September 2025.	Jane Moore, Executive Director of Public Health	31/12/2025			1) Business continuity standard operating procedure currently uploaded to the Resilience pages on Betsi Net was dated September 2022. This has been reviewed and fully updated. 2) The business continuity plan template and business impact analysis template have been updated to incorporate cyber risk assessments. The cyber content has been agreed with the cyber team. 3) The business continuity management policy has also been brought up to date and the business continuity operational response framework has ~~also been established~~
1679	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.2 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	2.2 Agree benefits reporting structure with the Executive Team to demonstrate the value of projects across various BCUHB governance groups outside of the DDaT Team.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			In progress. To be picked up with Head Of Digital Delivery, Strategy And Engagemen on return from annual leave.
1680	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.3 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	2.3 Review the Benefits Framework to include updated reporting and escalation routes.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			An SBAR went to DPDG on 18/11/25 recommending a revision to Section 11 - Benefits Governance of the Benefits Management Framework, describing the Forums and Reporting structures that should be established at Owner, Project, Programme and Portfolio Level. Recommendation approved and Benefits Framework updated to reflect. Further work is required to enhance the Reporting and Tracking elements of the framework.

1702	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	1. Governance We reviewed the governance arrangements in place and noted the following limitations: • The Health Board does not have an overarching policy or written control documents in place to support operational processes and ensure regulatory engagement, implementation, compliance, and escalation are managed consistently. • The Health Board does not retain a central register of regulatory reporting routes. Due to low engagement, we were only able to establish the key Health Board contacts for ten of the twenty-two known regulators • Areas / services have developed processes to manage regulatory reports and engagement independently – there is no consistent escalation	• An overarching policy and associated written control document will be approved to support operational processes and ensure regulatory engagement, implementation and compliance, ensuring escalation is managed consistently. • A central register of regulators as well as Executive Team Member lead, and regulatory reporting routes • The Corporate Governance Directorate to work with areas/services to develop processes to manage regulatory reports and engagement independently.	Pam Wenger, Director of Corporate Governance	31/03/2027			Work around legislative and regulatory compliance will commence in Q1 of 2026, once the revised corporate policy management process and policy documents have been approved and implemented. There is considerable work to be done around the legislative and regulatory compliance before a policy and any associated procedures can be fully developed.
1703	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	2.1 Regulatory Assurance Group (RAG) The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference as “the single point of focus for healthcare related regulation oversight and assurance activity across the Health Board” – the Group’s oversight is restricted to a limited number of regulators / regulatory reports (HIW, CIW, PSOW, and HSE). Note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.	The Health Board has existing arrangements in place and the spirit in which the Regulatory Assurance Group was established was to focus on the Regulators as defined in the Duty of Quality. Therefore to avoid any confusion, it is recommended that the Terms of Reference are reviewed. • Review the Terms of Reference to reflect the role of the Group in line with the Quality Regulation Policy	Pam Wenger, Director of Corporate Governance	31/03/2026			The TOR's for BCUHB Regulation and Governenace Meeting have been reviewed. They currently align with BCUHB Quality Regulatory Policy. There is a need for all organisational regulatory bodies to be scoped and identified to inform what would be an appropriate forum to capture and monitor or if a new forum needs to be created. This would not be within the portfolio of the Quality Directorate. An appropriate action owner would need to be identified to progress an organisational forum to capture all health board regulatory needs.
1704	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	2.2 Regulatory Assurance Group (RAG) The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference as “the single point of focus for healthcare related regulation oversight and assurance activity across the Health Board” – the Group’s oversight is restricted to a limited number of regulators / regulatory reports (HIW, CIW, PSOW, and HSE). Note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.	The Health Board has existing arrangements in place and the spirit in which the Regulatory Assurance Group was established was to focus on the Regulators as defined in the Duty of Quality. Therefore to avoid any confusion, it is recommended that the Terms of Reference are reviewed. • To develop a corporate procedure and reporting routes for the monitoring of regulatory reports at a corporate level; eg, MHRA, HSE and other regulators	Pam Wenger, Director of Corporate Governance	31/03/2026			The Executive Committee has agreed to the creation of a Governance and Compliance Group, and work is ongoing to develop the draft terms of reference and membership of that Group. It is proposed that regulatory compliance will be reported into that Group, and the processes around that are being developed. Work around the future of the Regulatory Assurance Group will be considered as part of this exercise.
1705	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	3. Operational Processes For the ten regulators reviewed, we confirmed that processes have been established locally to manage and implement required improvement actions to ensure compliance with regulatory requirements. However, we noted the following limitations: • Regulatory reports are not managed consistently across the Health Board - processes, reporting, and escalation arrangements vary by regulator, area, and / or service. • There are no formal processes or requirements to support the management, sharing, implementation, and tracking of wider learning from regulatory reports. • We were unable to verify the robustness and consistency of oversight and escalation arrangements from the evidence provided and could not confirm that regulatory assurance is consistently provided to the Board.	• A consistent process will be implemented to manage regulatory reports to include reporting and escalation arrangements by regulator to ensure robustness and consistency of oversight and escalation arrangements • High level reporting against regulatory reports will be included in the statutory compliance report to Audit Committee as well as individual oversight by committees as per the Scheme of Delegation.	Pam Wenger, Director of Corporate Governance	31/03/2027			Work around legislative and regulatory compliance will commence in Q1 of 2026, once the revised corporate policy management process and policy documents have been approved and implemented. There is considerable work to be done around the legislative and regulatory compliance before a policy and any associated procedures can be fully developed.

1706	Learning – Regulatory Reporting	2025	Limited	High	Objective 2: There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	4. Learning (Process) There is no policy or other formal written control documents in place outlining the requirements regarding the extraction, management, sharing and tracking of learning from regulatory reports. Regulatory reports and notices do not typically specify wider learning - they provide defined improvement actions needed to meet regulatory standards. Despite this, examples of wider learning being extracted and shared were provided for review. However, we cannot be assured that this is consistent for all regulatory reports, or that all opportunities for learning are captured.	The Executive Committee has established a Learning and Discovery Group which will focus on the learning from external reports and inquiries, this will ensure that learning is extracted implemented in the Health Board Agreed Action: • Develop Standard Operating Procedure outlining how learning is to be extracted, shared, tracked, and implemented.	Pam Wenger, Director of Corporate Governance	31/03/2026			A referral process for the Discovery and Learning Steering Group was created back in September 2024, which details the nine steps within this process, from initial referral of the report, triage and validation by the Statutory Compliance Team, through to the implementation of actions, monitoring of actions and feedback loop. A copy of that referral process is included as evidence. This detail will now be transposed into a procedure template, and follow the Health Board's approval process for such a document.
1707	Learning – Regulatory Reporting	2025	Limited	High	Objective 2: There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	5. Implementation and tracking of learning The Health Board does not have a formal system to track the implementation and impact / outcome of shared learning from regulatory reports. For the examples provided, we were able to confirm that the relevant learning had been shared, however could not confirm in all cases that required actions were subsequently implemented / actioned.	The finding in this recommendation is linked to the key finding in 1 and this is already included in the work programme as described in the IMTP. The action will therefore be aligned to the Board approval of the IMTP. Agreed Action: • Develop and implement a formal system to track the implementation and impact of shared learning from regulatory reports across the Health Board.	Pam Wenger, Director of Corporate Governance	31/03/2027			Work around legislative and regulatory compliance will commence in Q1 of 2026, once the revised corporate policy management process and policy documents have been approved and implemented. A system to capture and disseminate such information is also required in order to ensure that this information is fully accessible, and has the ability to cross-reference and link between the different legislation and regulations.
1749	Complaints management	2025	Limited	High	Objective 2: Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	3. Learning and Improvement Plan action plans – Compliance with Policy No supporting evidence was noted in our review of DATIX to confirm the closure of actions, despite these being recorded as complete and closed. We also confirmed that no routine audits are being undertaken by the Complaints Team to verify the closure of actions are supported – This is a breach of PTR 01 Integrated Concerns Policy – paragraph 16.7.	PTR 01 Integrated Concerns Policy – paragraph 16.7 has been changed to ensure clearer wording that the learning from complaints must be evidenced and recorded by services. In addition to this the health board is in the final stages of developing a dedicated learning repository to support evidence gathering on agreed learning actions identified in the complaints process.	Angela Wood, Executive Director of Nursing and Midwifery	01/08/2026			Integrated concerns and complaints policy section 16.7 is currently being changed, to provide more detailed narrative that the responsibility for embedding and evidencing learning lies with operational services and not corporate services
1751	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	1. Procurement training Welsh Health Circular (WHC/2024/013) Governance on interim appointments to Executive and Senior Positions requires "Procurement training is mandatory and must be in place for all Executive Directors and all staff involved in procurement". We obtained details of officers who have attended procurement training from the Finance Directorate who maintain the list of attendees. We noted recently appointed Executive Directors are yet to receive their mandatory procurement training. We reviewed a sample of officers delegated to approve requisitions against the training records	• Develop and maintain a register of all officers required to complete procurement training exploring the use of ESR to record compliance (Director of Workforce and OD); and • Schedule mandatory sessions for Executive Directors and delegated officers (Director of Workforce and OD)	Carol Shillabeer, Chief Executive	31/12/2025			<i>Audit report received after request for updates submitted</i>

1752	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	2. Accountability Agreements Accountability Agreements detail explicitly the expectations of Budget Holders, including: 'I will adhere to the Health Boards approved Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, specifically in regards to recruitment and commissioning of goods and services; I will attend a mandatory session for Procurement of goods and services (dates to be shared) hosted by Procurement Shared Services for Wales, it is my responsibility to ensure I attend one of the planned sessions once dates are confirmed. Ensure as far as I am able that all non-pay expenditure complies with the requirements of the Standing Financial Instructions including the requirement for an official purchase order to be raised in advance of incurring the expenditure'. The review of data obtained from the Finance Directorate concerning the status of Tier 1 (Chief Executive) and Tier 2 (Executive/Corporate Directors) Accountability Agreements, as of 2 October 2025, for the 2025/26 financial year notes nine(64%) recorded as not replied to the request to sign the agreement; one (7%) recorded as refusing to sign the agreement; and four (29%) signing the agreement. We are aware that	• Ensure all Tier 1–2 officers sign Accountability Agreements for 2025/26. • Escalate non-compliance to Audit Committee with reasons for refusal	Carol Shillabeer, Chief Executive	31/12/2025			Audit report received after request for updates submitted
1753	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	3. Declarations of Interest (DOI) Health Board Policy OBS02 Standards of Business Conduct paragraph 8.6 requires "Mandatory annual declarations of interests are required from....all senior employees (band 8c or equivalent and above),.....and also other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)". Our review of ninety officers who approved requisitions for a purchase order to be raised found thirty-one (34%) did not have up to date declarations recorded with thirteen (14%) having made no declaration. We were unable to confirm Directors had formally considered the requirement to identify "....other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)". All officers with delegated authority and/or who engage with suppliers have the potential for conflicts of interest when procuring goods and services on behalf of the Health Board.	• Identify all roles with delegated authority or procurement responsibilities via the budget holders register held by Finance • Require annual DOI submissions for these roles.	Carol Shillabeer, Chief Executive	31/01/2026			Audit report received after request for updates submitted
1754	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	4. Direct Call Off (DCO) framework use The review of DCO evidence does not demonstrate the Health Board has consistently achieved best value in the selection of suppliers for DCO awards where officers are routinely undertaking DCO with suppliers, without engaging NWSSP Procurement Services first to ensure best route to the market. The NHS Wales Procurement Manual states “Depending upon the requirement and value of the opportunity, ‘direct call off’ may not offer the best value solution overall. The lead and Procurement Lead will consider this at the planning stage. Suppliers should be invited to bid via the Procurement Service appointed e-	• Procurement training to ensure the reduction in Direct Call Off by engaging NWSSP Procurement Services at planning stage. • Monitor and report DCO usage quarterly (via procurement report)	Carol Shillabeer, Chief Executive	31/03/2026			Audit report received after request for updates submitted

1755	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	5. Compliance with the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) There are detailed expected controls in the Standing Financial Instructions, relating to procurement, that have been refreshed to align with the Procurement Act 2023 and Health Services (Provider Selection Regime) (Wales) Regulations 2025). A review of the procurement data in our sample has identified the following SFIs that show inconsistent compliance: • Procurement advice is sought from Procurement Services at the outset (SFI 11.3.6). • Effective planning of procurement exercises with Procurement Services was soon as possible to ensure compliance with minimum competition thresholds (SFI 11.9.2). • For ‘Goods and Non-Health Services Only’, advice from Procurement Services is sought for all requirements in excess of £5,000 (excluding VAT) (SFI 11.11.2). • No Purchase Order, No Pay where retrospective requests have been made to facilitate payment of an invoice (SFI 11.19). We found inconsistent compliance between the	• Deliver update sessions on revised SFIs and SoRD to all Executive and Corporate Directors. • Notify NWSSP Procurement Services of all delegated officers authorised to sign contracts. • Ensure all contracts are signed by authorised officers before commencement.	Carol Shillabeer, Chief Executive	31/03/2026			<i>Audit report received after request for updates submitted</i>

OPEN EXTERNAL AUDIT RECOMMENDATIONS

ID	Report Title	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementat ion date	Revised implementati on date	Number of Revisions	Update at 15/12/2025
0394	Structured Assessment 2022	Recommendation 12: Improve performance and financial oversight for digital and estates	R12b: There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the	R12b: Although addressing deficiencies and risks are the priority proof of value, work in small affordable pockets are progressing and demonstrating the benefits that can be delivered if scaled.	Dylan Roberts, Chief Digital and Information Officer	31/12/2023	31/03/2026	2	Currently no further update.
0399	Structured Assessment 2023	Recommendation tracking	R5a: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	R5a: Agreed. A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non audit bodies. This includes QSE Committee and a People and Culture Committee.	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	The Executive Committee has agreed to the creation of a Governance and Compliance Group, and work is ongoing to develop the draft terms of reference and membership of that Group. It is proposed that regulatory compliance will be reported into that Group, and the processes around that are being developed.
0400	Structured Assessment 2023	Recommendation tracking	R5b: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	R5b: The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinate and have appropriate oversight at Committee and where appropriate Board level.	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	The Executive Committee has agreed to the creation of a Governance and Compliance Group, and work is ongoing to develop the draft terms of reference and membership of that Group. It is proposed that regulatory compliance will be reported into that Group, and the processes around that are being developed.
1453	Structured Assessment 2024	Recommendation 2	R2. In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role.	R2: Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team. Key actions include: • Review of the operational governance arrangements including the role of the Senior	Pam Wenger, Director of Corporate Governance	31/07/2025	28/02/2026	1	The review of the role and function of the Senior Leadership Team is progressing as part of the Foundations for the Future Programme. The revised implementation date remains 28 February 2026, and work is continuing to ensure clarity on roles and responsibilities for both the Senior Leadership Team and the Operational Leadership Team.
1456	Structured Assessment 2024	Recommendation 5	R5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board.	R5: The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. Key actions include: • Agree how the Board can engage with services, which will include plans in terms of service reviews; • Establish a reporting mechanism to the Board in terms of service visits	Pam Wenger, Director of Corporate Governance	30/06/2025			This approach was Approved at the Board Meeting on Thursday, 27 November 2025

1463	Review of Cost Savings Arrangements	Recommendation 1.2	R1.2: The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.2: Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target.	R1.2 The articulation of demand and capacity by speciality and comparison to national metrics will enable allocative efficiency models to be endorsed. This will depend largely upon formation of the above speciality plans and Corporate benchmarking that will occur prior to and during 2025/26.	Russell Caldicott, Executive Director of Finance	31/10/2025			Work is continuing on exploring the opportunities identified to ensure they are sufficiently robust to incorporate to the 2026/27 financial plan.
1467	Review of Cost Savings Arrangements	Recommendation 2.3	R2.3: The Health Board should strengthen its approach to the identification and delivery of savings by: R2.3: Maintaining a focus on the identification of saving schemes that deliver recurrent savings.	R2.3 The Annual Plan (endorsed by the Board) sets out the expectation to deliver the annual savings requirement on a recurrent basis. The 2023/24 Full Year Effect (FYE) outturn was £26.3m which was in excess of the required target £25.2m. The 2024/25 current recurrent FYE forecast against the £48m Savings Target stands at £39.2m (at Month 6).	Russell Caldicott, Executive Director of Finance	31/03/2025			As at month 8 savings are estimated to deliver at £43.4m. The FYE impact of the recurring savings and additional income generation is £32.8m
1470	Review of Cost Savings Arrangements	Recommendation 3.1	R3.1: When updating its savings guidance, the Health Board should ensure: R3.1: That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas.	R3.1 The Health Board launched Small Change Big Difference in 2023, which sought ideas from all staff. We will continue to progress and follow up on these initiatives to secure enhanced savings delivery.	Russell Caldicott, Executive Director of Finance	Ongoing 2025			This agenda item was deferred and will be rescheduled for a future V & S Programme board shortly.
1514	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commisioning Manager)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	01/06/2025	1	Significant progress has been made in giving access to LA colleagues to the Right Patient Right Place Dashboard. This is due to go live in December. This will allow LAs to view how many patients are delayed and the reason - this will support more timely and priority interventions
1520	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 8. Actively seek ways to increase local authority access for systems held within BCUHB. (OWNER: Acting Assistant Director of Care Homes Support)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	31/04/2025	1	This system will be accessible to all LAs by December. Training for LA colleagues has commenced.
1708	Urgent and Emergency Care: Arrangements for Managing Demand	Identifying data used to inform plans for urgent and emergency care	R1 To ensure that priorities reflect and align to up to date information such as service demand, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its plans for urgent and emergency care.	R1. The 6 Goals Delivery Plan includes specific benefits and measures to monitor the progress against the priorities for the 4 UEC workstreams. A number of Power BI dashboards have also been established to support access to a range of live data across UEC, enabling oversight of activity across acute and community sites, any emerging pressures and monitoring delayed patients. UEC data will be reviewed within the IHC local governance structures for UEC, the UEC programme board and UEC internal focus group to continue to inform plans and priorities.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			The UEC programme board has been further refreshed following the appointment of a new UEC Programme Director (commencing January 2026) and a UEC clinical lead. Meetings for both UEC internal focus group and wider external UEC group have been established to support robust oversight and governance with revised Terms of Reference. Each workstream provides updates through a standardised template for review at UEC meetings. A number of key UEC targets have been identified for immediate delivery including: ambulance handover >45 mins; median time from arrival at ED to triage by clinician; median time from arrival at ED to assessment by clinical decision maker; reduction in numbers waiting > 4 hours; reduction in numbers waiting 12 hours and a reduction in number of POCDs. The Right Patient Right Place dashboard, has been further developed providing real-time, patient information at a glance so staff both in hospital and community and is now also accessible for social services teams to see exactly where a patient is in the hospital, how long they have been there and what they need for dishcharge planning.
1709	Urgent and Emergency Care: Arrangements for Managing Demand	Risk management within plans	R2.1 To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions.	R2.1 The 4 UEC workstreams have RAID logs that are either developed or in development that include risks, actions, issues, decisions which are reviewed during each workstream meeting that are held regularly with standard agendas.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			The 4 UEC workstreams present update reports to the UEC programme board routinely that is aligned to the online planning portal with details actions, leads and status of completion. A UEC risk register has also been created that is routinely reviewed at the Programme board.

1710	Urgent and Emergency Care: Arrangements for Managing Demand	Risk management within plans	R2.2 To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions.	R2.2 A Health Board corporate risk CRR25-01 (Timely Patient Access to Safe & Effective Care) includes mitigating actions and controls across UEC as well as wider services.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			Corporate Risk CRR25-01 for Timely Patient Access to Safe & Effective Care has been reviewed and updated and presented to Risk Scrutiny Group as part of a UEC deep dive on 9th December 2025. The actions and mitigating controls will continue to be monitored to support delivery of actions by target risk date. A clinically led Urgent & Emergency care task team has also been established taking decisive steps with senior clinical leads and operational teams to support system wide improvements and with a focus on 3 key areas i) reducing avoidable admissions and ambulance conveyands to EDs; ii) improving flow through the hospital including establishing an acuity led discharge process and improved weekend flow; iii) working with clinical and operational teams to strengthen system working. A presentation was also provided to Audit committee in December 2025 on all open audit recommendations including against CRR25-01 and BAF24-07 both relating to timely patient access to care.
1712	Urgent and Emergency Care: Arrangements for Managing Demand	Resourcing urgent and emergency care plans	R4 To provide clarity on how initiatives will be funded beyond the annual plan cycle, the Health Board should ensure its plans for urgent and emergency care clearly identify funding needs for current and future years, as well as identifying the ~~sources of funding~~	R4. Additional 6 Goals funding has been made available nationally, which is contingent on a detailed financial plan and which has been submitted to the national NHS P&I team. As regional service models are developed, resource implications will be integrated into annual financial plans and within the IMTP.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			The Health Board continue to work with the national P&I team on the progression of UEC priorities in line with funding for agreed prioiries i.e. implementation of SPOA and Falls
1713	Urgent and Emergency Care: Arrangements for Managing Demand	Resourcing urgent and emergency care plans	R5 To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements	R5. Workforce requirements will be assessed as part of the development of a regional model for urgent and emergency care and to support requirements of R4.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			All workforce requirements will be included within the reconfiguration of Foundations for the Future
1714	Urgent and Emergency Care: Arrangements for Managing Demand	Improving information on alternative services	R6 To help guide patients to the most appropriate service for their needs, the Health Board's website should include advice on key urgent conditions, such as breathing difficulty, chest pain or rashes	R6 The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			A UEC communications plan has been approved and is in place, approved through the UEC internal focus group. The comms plan sets out the Health Board's commitment to leadership in recognition of the scale of the challenge for UEC and that it is a priority for the Health Board to address the many challenges across the whole ssystem with clear co-ordinated actions. The Plan also includes a communications activity schedule to stakeholders includng staff, public and WG.
1715	Urgent and Emergency Care: Arrangements for Managing Demand	Improving information on alternative services	R7 To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance	R7 The BCU website includes information about local primary care services; including access to dental and GP services that includes a page with a directory of information of all GP practices in NW as a core part of seasonal campaigns to sign post to information.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			A UEC communications plan has been approved and is in place, approved through the UEC internal focus group. The comms plan sets out the Health Board's commitment to leadership in recognition of the scale of the challenge for UEC and that it is a priority for the Health Board to address the many challenges across the whole ssystem with clear co-ordinated actions. The Plan also includes a communications activity schedule to stakeholders includng staff, public and WG.

1716	Urgent and Emergency Care: Arrangements for Managing Demand	Improving information on alternative services	R8 To support staff and public understanding of the breadth of urgent and emergency services within the Health Board, and how to access them, the Health Board should develop a communications plan for urgent and emergency care services.	R8: A GMS sustainability action plans includes a focus on public comms, including identification of relevant items for communication and work is ongoing with corporate comms team to agree a communications plan including how community pharmacies can support. The website also includes a link to NHS 111 providing information and a point of signposting which includes all directories for primary care services and is the single point of contact in terms of supporting the public with decisions on these services. The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the ‘Help Us Help You’ campaign	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			A UEC communications plan has been approved and is in place, approved through the UEC internal focus group. The comms plan sets out the Health Board's commitment to leadership in recognition of the scale of the challenge for UEC and that it is a priority for the Health Board to address the many challenges across the whole system with clear co-ordinated actions. The Plan also includes a communications activity schedule to stakeholders including staff, public and WG.
1717	Urgent and Emergency Care: Arrangements for Managing Demand	Improving information on alternative services	R9 To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task.	R9: A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			In addition to the wider UEC programme clinical lead, a separate clinical lead has been appointed providing 2 x SPAs to provide specific focus on the implementation of a single point of access (SPOA) through UEC Workstream 1 and is aligned to the national SPOA framework. This work will progress in line with the programme plan
1718	Urgent and Emergency Care: Arrangements for Managing Demand	Maximising use of SDECs and UPCCs	R10 To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee	R10: As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance review of the SDEC units during October 2025.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			A review of SDECs has been undertaken by the national NHS P&I team and is part of the programme of work within UEC Workstream 2 with the development of Front Door Acute Frailty Units. Feedback has been provided which will inform the actions to be progressed through the workstream and programme, led by programme director and workstream lead. The Programme team continue to work with the national P&I team to progress the priorities for this workstream to develop the acute frailty model in NW.
1719	Urgent and Emergency Care: Arrangements for Managing Demand	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: R11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria	R11.1: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			The Health Board continue to work with the national P&I team to develop the model in NW
1720	Urgent and Emergency Care: Arrangements for Managing Demand	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: R11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed	R11.2: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			The Health Board continue to work with the national P&I team to develop the model in NW
1721	Urgent and Emergency Care: Arrangements for Managing Demand	Maximising use of Minor Injuries Units	R12 To understand how well it is utilising Minor Injuries Units and to identify further opportunities to maximise this service, the Health Board should include metrics on attendance and conveyance rates to its minor injuries units and medical assessment units in reports to the Finance and Performance Committee.	R12: A power BI dashboard is established that includes a suite of reports for MIU performance data including number of attendances, time to triage & clinician / number of breaches. UEC data will be reviewed and scrutinised within the UEC programme board and other relevant forums as agreed with the COO to inform the development of plans and priorities.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			Live MIU data is available and performance reviewed at daily system resilience calls
1722	Urgent and Emergency Care: Arrangements for Managing Demand	Improving staff and patient feedback	R13 To ensure future plans for urgent and emergency care are informed by patient experience, the Health Board should clearly demonstrate within the narrative how it has considered patient feedback.	R13: The UEC programme board receives a patient story as a standing item on the agenda. A review of complaints and compliments is routinely undertaken by IHCs respectively. As part of the focused work within UEC workstream 4, Discharge Improvement Groups have been established in each of the 3 IHCs to review discharges that are considered to provide learning, identify themes and trends. Targeted work has been done with care homes and actions to improve the patient experience which is included within care home awareness seminars. Follow up audits have been undertaken in the 3 ED departments specifically for attendances from care homes into the EDs. This has included engagement with staff from care homes & EDs. Learning from this has been incorporated into the ongoing care home awareness webinars that are being rolled out across NW within a rolling programme of	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			Patient stories are included as a standing item on the UEC Programme Board to share learning and good practice.

1724	Urgent and Emergency Care: Arrangements for Managing Demand	Reporting of expenditure of additional funding for UEC services	R15 To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies	R15: The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025				The new programme director starting 5th Jan will review all spend against the financial plan and reports will be presented to the revised UEC Programme Board

AUDIT RECOMMENDATIONS AWAITING LEAD EXECUTIVE CLOSURE APPROVAL

ID	Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Update at 15/12/2025
0488	Internal Audit	Health and Safety - 2024	2024	Limited	High	Matter Arising 1: Policies & Procedures (Operation)	1.1b: Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board	1.1b: The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.	Carol Shillabeer, Chief Executive	Immediately	Occupational health and safety is now aligned to the Executive Director of Workforce and Organisational Development rather than the Director of Environment and Estates
1309	Internal Audit	Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005	2024	Reasonable pre 01/10/2024	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	30/11/2024	Resolved
1317	Internal Audit	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 4: Procurement Training (Operation)	4.1 The recording of all procurement training, as required by the Welsh Health Circular and Accountability Agreement is ensured by assigning 050 LOCAL Procurement Financial Training - 3 Years Information and Knowledge to mandatory training for: • All Executive and Board level Directors, including direct reports to the Chief Executive. • All Officers in receipt of Accountability Agreements. • All other Officers involved in Procurement. • All officers who have completed the training to date, up to a minimum time e.g. 1 hour or more have their record updated in ESR.	4.1 The process of updating competencies will be reviewed and updated to ensure new and existing Board level Directors and staff receive the ESR competency and that Remuneration Committee will receive routine updates on compliance with this training requirement.	Carol Shillabeer, Chief Executive	28/02/2025	All Executive Team members undertook training around procurement with the NWSSP Head of Operational Procurement and National Sourcing on 03/12/2025.
1753	Internal Audit	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	3. Declarations of Interest (DOI) Health Board Policy OBS02 Standards of Business Conduct paragraph 8.6 requires "Mandatory annual declarations of interests are required from....all senior employees (band 8c or equivalent and above),.....and also other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)". Our review of ninety officers who approved requisitions for a purchase order to be raised found thirty-one (34%) did not have up to date declarations recorded with thirteen (14%) having made no declaration. We were unable to confirm Directors had formally considered the requirement to identify ".....other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)". All officers with delegated authority and/or who engage with suppliers have the potential for conflicts of interest when procuring goods and services on behalf of the Health Board.	• Identify all roles with delegated authority or procurement responsibilities via the budget holders register held by Finance • Require annual DOI submissions for these roles.	Carol Shillabeer, Chief Executive	31/01/2026	All budget holders have been contacted as part of the update to the Standing Orders. We are now identifying a way to align these to the declarations captured on the Civica System to ensure that they all have DOI's submitted. This relates to all 8c and above – budget holders and is in line with the SOBC policy.

INTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE FINAL CLOSURE APPROVAL

Recommendations outside Internal Audit review scope
Recommendations approved for closure by Internal Audit following review

ID	Report Title	Year	Overall Report rating - from Jan 2025	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementat ion date	Last update	Recommendation state
0471	Discharge Arrangements	2024	n/a	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1c (ii): Management: - Establish formal escalation framework to address and support resolution of Pathways of Care Delays. - Ensure working practice complies with Welsh Government requirements.	3.1c (ii): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 2	Tehmeena Ajmal, Chief Operating Officer	30/09/2024	Monthly meetings at a NW region including H&SC colleagues are held with the NHS Executive team overseeing the work for the ministerial targets that includes the POCDs performance. POCD action plan that has been developed with LA partners has been provided as evidence against this action together with slides presented at the NW regional meetings.	IA closure approval
0476	Discharge Arrangements	2024	n/a	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1 (iii): Management: - Establish formal escalation framework to address and support resolution of Pathways of Care Delays. - Ensure working practice complies with Welsh Government requirements.	3.1d (iii): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. QUARTER 3	Tehmeena Ajmal, Chief Operating Officer	31/12/2024	Monthly meetings at a NW region including H&SC colleagues are held with the NHS Executive team overseeing the work for the ministerial targets that includes the review of Trusted Assessor roles and functions. TA action plan that has been developed with LA partners has been provided as evidence	IA closure approval
0477	Discharge Arrangements	2024	n/a	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1 (iv): Management: - Establish formal escalation framework to address and support resolution of Pathways of Care Delays. - Ensure working practice complies with Welsh Government requirements.	3.1d (iv): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. QUARTER 4	Tehmeena Ajmal, Chief Operating Officer	31/03/2025	Monthly meetings at a NW region including H&SC colleagues are held with the NHS Executive team overseeing the work for the ministerial targets that includes the review of Trusted Assessor roles and functions. TA action plan that has been developed with LA partners has been provided as evidence	IA closure approval
1339	Corporate Legislative Compliance - Fire Safety	2024	n/a	Limited	High	Matter Arising 1: Governance (Design)	1.1a Reporting and committee structure should be reviewed and agreed to ensure there are appropriate governance arrangements in place to receive assurance on fire safety.	1.1a Reporting structure to be reviewed and align with escalation processes set out within the Health Board	Stuart Keen, Director of Environment and Estates	10/04/2025	Terms of Reference has been updated to reflect the new reporting structure, and approved at the Fire Safety Management Group meeting on 01/05/2025 - item 4 refers to the TOR.	IA closure approval
1522	Clinical Audit - 2025	2025	Limited	Limited	High	Objective 2: There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.	2. Development of Tier 2 audit plan We have been unable to evidence standardised formal assessments being undertaken for the Tier 2 audit plan and it is unclear how the plan has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides rationale for the areas on the plan. This issue was also raised as a high priority within the 2022 audit review.	2. Through Strategic Clinical Effectiveness Group there has been process where the current Tier 2 audit was reviewed and discussions on which audits needed to be carried over into the new audit plan for 2025-2026. Also as noted above, the group was asked to consider and identify from specific local risk, strategic interest and concerns. In order to capture this a new table for the audit plan has been developed which will provide details needed to provide assurance of the rational.	Sreeman Andole, Interim Executive Medical Director	11/04/2025	Tier 2 will be reviewed on COB every six months.	IA closure approval
0276	Accounts Receivable	2023	n/a	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 2: Financial Procedures (Design)	2.1 Management review and update relevant financial procedures as necessary to ensure they are fit for purpose	2.1 The updating of financial procedures is part of the Financial Control Environment Action Plan. Those requiring review will be prioritised and brought up to date as required.	Russell Caldicott, Executive Director of Finance	30/09/2023	Local Counter Fraud Policy is now complete and has been signed off. Charity policies included as evidence	Outside scope of IA review

0499	Effective Governance – Women’s Directorate	2024	n/a	Reasonable pre 01/10/2024	High	Matter Arising 3: Clinical Audit (Operation)	3.1: The Directorate SLT ensures it has an effective clinical audit programme operating at Tier 3 and it contributes to Tier 2 audits with findings and lessons learnt shared pan-Directorate and Health Board wide where relevant	3.1: The Women’s Directorate will review the effectiveness of the Service’s Clinical Audit Programme operating at Tier 3 and at Tier 2. The Women’s Directorate will review how Audit findings and learning is shared across the service and with relevant stakeholders and take appropriate action to improve current performance. The Women’s North Wales Clinical Audit Lead Role and function has been reviewed by the Women’s SLT and now includes clinical effectiveness and governance responsibilities. Additional time has been allocated per week to reflect these additional responsibilities. This role also supports the designated Audit Leads/ Unit. The Directorate will ensure that Site Audit leads are able to attend the Women’s Services Clinical Effectiveness Group (CEG) monthly meetings in order to update on Tier 2 and 3 audit progress and to ensure flow of information from CEG to the individual departments. This will be job planned per the 3rd SPA given for this role. Audit Leads will be required to provide monthly reports on Tier 2 and 3 audit progress including a summary of new/ongoing and completed Tier 3 audits. <u>This will include key learning from the audit</u>	Imran Devji, Interim Chief Operating Officer	30/06/2024	Womens Services CEG meeting from January 2025 is being moved from the third Wednesday monthly, to the fourth Wednesday monthly to accommodate all three Clinical Site Audit Leads to be able to attend, which will strengthen assurances on Tier 2 and Tier 3 level audits. Both Tier 2 and Tier 3 updates are listed on the standard agenda for all meetings. Updates will be received from the Clinical Effectiveness and Audit Lead and the 3 x site Clinical Audit Leads.	Outside scope of IA review
0500	Effective Governance – Women’s Directorate	2024	n/a	Reasonable pre 01/10/2024	High	Matter Arising 4: Concerns, Complaints, Incidents et al (Operation)	4.1a: The Director of Midwifery and Women’s Services: - Ensures the Directorate responds to all complaints according to expected reporting timelines and all learning is shared across the Directorate. - Reviews the reasons why Celyn Ward, Ysbyty Glan Clwyd is an outlier with complaints and takes steps to address the issues raised. - Ensures the reporting of all concerns, complaints, incidents et al is reported and scrutinised in accordance with the Directorate’s governance structure.	4.1a: The Women’s Directorate continues to prioritise investigation and closure of all concerns with a concerted effort to comply with the Welsh Government 30 day closure target. The Service’s forecasted performance trajectory is to close 75% of all concerns by the end of June 2024. The Directorate is working with the Corporate Concerns Team in the development and implementation of a BCU-wide Concerns Performance Dashboard. The Service’s performance against the agreed trajectory is monitored weekly by the Office of the Nurse Director and at the Concerns Performance Escalation Meetings chaired by the CEO.	Tehmeena Ajmal, Chief Operating Officer	30/06/2024	Current compliance 77.27%. Concerns continue to be reviewed twice weekly operational meeting which feeds into the weekly Women's Integrated Concerns Meeting. The Service present their Incidents and Concern position to the Corporate Concerns and Incident's meeting on a weekly basis. As noted in the previous update Celyn Ward, Ysbyty Glan Clwyd is not an outlier with any trends to note.	Outside scope of IA review
0529	Digital Operating Model	2023	n/a	Reasonable pre 01/10/2024	High	Matter Arising 3: Business Relationships (Operation)	3.1: Recruitment to the business relationship manager and architect posts should continue as a priority.	3.1: Business relationship manager and architect posts to be appointed subject to the ECR/ER process and suitable candidates.	Dylan Roberts, Chief Digital and Information Officer	30/04/2024	All posts have now been appointed to - Solution Architect - ECR: 65281. BRM - ECR: 57526.	Outside scope of IA review
1245	Budgetary Control User access & Delegated limits	2023	n/a	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Business Systems Team Housekeeping (Operation)	3.1a: The Head of Business Systems: Considers enhancing the end-date of users after a period of inactivity in accessing E-Financials – This timeline should be risk based and consistent with peers across NHS Wales.	3.1a: Systems will develop an enhanced process of reviewing user access across Oracle and QlikView and comparing user accounts with ESR assignments. Once the manual process is developed, we will look to build an automated robotic process.	Russell Caldicott, Executive Director of Finance	30/09/2023	Following successful pilot and testing of the new improved Oracle leavers process the new system fully live	Outside scope of IA review
1313	Value Based Healthcare	2024	n/a	Reasonable pre 01/10/2024	High	Matter Arising 1: There is effective oversight of initiatives and reporting to the Board, via it’s Committees (Operation)	The Health Board confirms the governance reporting structure to receive assurance and scrutinise progress on VBHC.	The Health Board is currently in the process of reviewing the governance of Value and Sustainability groups. There is an expectation that VBHC will be incorporated as part of the governance and reporting framework for Value and Sustainability; to ensure there is effective oversight of initiatives and reporting to the Board, via it’s Committees, to provide assurance on progress in implementing Value-Based Health Care.	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	31/12/2024	The VBHC Programme currently reports within the organisation’s change portfolio via the Value and Sustainability Programme. The V&S programme board reports to the Integrated Performance Executive Delivery Group meeting chaired by the CEO; which in turn provides a Chair’s report to the Performance and Information Governance Committee. As per the recent recommendations within the Audit Report, the emerging governance structure, seeks to combine the previously separate Value Based Health Care & Value & Sustainability agendas into a single coherent ‘Value’ programme, with an appropriate accountability framework to oversee progress. Following informal advice on the development of the governance structure from Pam Wenger in Dec-24, it will be presented for approval at the inaugural Programme Board on 27.01.25 for ratification.	Outside scope of IA review

1314	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	n/a	Reasonable pre 01/10/2024	High	Matter Arising 1: Appointment of Officer Members of the Health Board (Operation)	1.1 The Health Board formally appoints Officer Members (Chief Executive, Executive and Board Level (Director of Corporate Governance) Directors) in accordance with NHS Wales Regulations and its Standing Orders, following recommendation from the Remuneration Committee – This could be facilitated through the Remuneration Committee Chairs Assurance report. The Health Board should retrospectively, formally appoint all Officer Members of the Board who have started in post since April 2023.	1.1 The Remuneration Committee has responsibility for the approval of the appointments of the VSM posts as described in the terms of reference. However, where a Board Level appointment is made, the Board should ratify the appointment on the Board. This will be addressed going forward through the report from the Remuneration Committee.	Carol Shillabeer, Chief Executive	30/09/2024	The Audit Report will be considered at the next Committee and proposed the appointments will be ratified in the Board in November 2024	Outside scope of IA review
1316	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	n/a	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Authorised signatories on Payroll notification forms to NWSSP Payroll Services (Operation)	3.1 Health Board management addresses the conflict between the Scheme of Reservation and Delegation and Paragraph 4.5.2 of WP1E Recruitment to Very Senior Posts.	3.1 A local SoRD will be put in place that enables the Strategic Recruitment team to complete new starter Payroll forms for Senior appointments where there is clearly documented approval of the starting salary by the appointing Director and, where necessary, REMCOM.	Carol Shillabeer, Chief Executive	28/02/2025	The CEO has confirmed delegated authority for the Strategic Recruitment Team to complete new starter payroll forms for senior appointments where there is clearly documented approval of the starting salary by the appointing Director and, where necessary, the Remuneration Committee, which will be included in the CEO 'Local' SORD. It is recommended this action is closed.	Outside scope of IA review
1383	Intelligence Led Organisation	2024	n/a	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.4.3 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts	1.4.3 External Partners Identify further potential partners and explore opportunities for joint working with other universities in relation to health analytics and forecasting development.	Dylan Roberts, Chief Digital and Information Officer	31/03/2025	Initial exploration complete. Potential use of Knowledge transfer partnership agreement with Swansea university ongoing. Agreement in place to work with Bangor University on advanced analytics in the 25/26 academic year. Student MSc analytics project on Urgent and Emergency Care being scoped - student identified, project brief to be set	Outside scope of IA review
1388	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 3: Data Quality Policy (Operation)	3.1.1 A data quality policy should be developed	3.1.1 Review and amend WPAS user acceptability statements to clarify expectations and responsibilities in relation to data quality. This will be managed through the WPAS Operational Steering Group and Programme Board to gain operational approval	Dylan Roberts, Chief Digital and Information Officer	31/12/2024	Data Quality statement added to Systems Accetable use statement	Outside scope of IA review
1389	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 3: Data Quality Policy (Operation)	3.1.2 A data quality policy should be developed	3.1.2 Formalise data quality reporting processes through Operational data quality groups and clarify data quality standards and expectations aligned to metrics included in data quality dashboards.	Dylan Roberts, Chief Digital and Information Officer	31/03/2025	Operational Data Quality Groups in place across IHCs. Core agenda items identified and DQ dashboards used to guide discussion. Further dashboard developments will help focus attention to priority areas (ID1394) Action Completed. The Policy Development and Implementation is captured under Audit Recommendation 1391 which remains open.	Outside scope of IA review
1390	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 3: Data Quality Policy (Operation)	3.1.3 A data quality policy should be developed	3.1.3 Develop data quality training content to share with systems users as part of system training and ongoing support	Dylan Roberts, Chief Digital and Information Officer	31/03/2025	Data quality included in series of podcasts (audit action 1398). Bespoke training and guidance is provided to WPAS users in response to identified errors or changes to ways of working to accommodate initiatives such as insourcing, outsourcing and waiting list validation	Outside scope of IA review
1392	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 4: Data Quality Resolution (Design)	4.1.1 The use of the data quality table should be improved. This should be supported by a formal / agreed process for resolving / correcting identified issues with data quality within the clinical services.	4.1.1 Data Quality tables in use as part of the development of a data quality kite mark, to be applied to a planned care dataset (Q3 annual plan milestone)	Dylan Roberts, Chief Digital and Information Officer	31/12/2024	As reported against Q3 milestone 5D.2. Data model built and tested on a planned care dataset (RTT open pathways). Work to develop the visualisation of the data quality mark is ongoing	Outside scope of IA review
1393	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 4: Data Quality Resolution (Design)	4.1.2 The use of the data quality table should be improved. This should be supported by a formal / agreed process for resolving / correcting identified issues with data quality within the clinical services	4.1.2 Data quality measures to be developed and kite mark to be applied to second dataset based with plans for further roll-out to be included in the 2025/26 annual plan.	Dylan Roberts, Chief Digital and Information Officer	31/03/2025	Data model developed, kite mark applied to PTL report, subject to feedback will be applied to further waiting list datasets over the course of Q1. Details of data model and screen shot of kite mark applied to report submitted as evidence	Outside scope of IA review
1394	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 4: Data Quality Resolution (Design)	4.1.3 The use of the data quality table should be improved. This should be supported by a formal / agreed process for resolving / correcting identified issues with data quality within the clinical services.	4.1.3 Prioritisation of data quality activities to be formalised through Planned Care Data Planning and Performance workstream and WPAS Operational steering group to ensure focus is on areas likely to have most significant impact on service delivery e.g. waiting list management	Dylan Roberts, Chief Digital and Information Officer	31/01/2025	Data Quality priority measures identified for year end. Lessons learnt session to be held on 28th April to inform DQ dashboard developments. These will be used to inform agenda of Operational DQ groups.	Outside scope of IA review
1395	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 5: Data literacy (Operation)	5.1.1 The data literacy assessment should be undertaken, and training materials on data and its users should be provided, with targeted training provided to key staff tiers.	5.1.1 Planned Care Training needs assessment as part of NHS Wales Improvement Academy work, this will inform a work plan to support operational teams in the use of data to manage planned care services	Dylan Roberts, Chief Digital and Information Officer	30/11/2024	As reported against Q3 annual plan milestone 5D.4. Training needs assessment undertaken as part of NHS Executive survey of planned care staff. Operational teams asked to indicate support required, awaiting detail of responses from NHS Executive Team.	Outside scope of IA review

1396	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 5: Data literacy (Operation)	5.1.2 The data literacy assessment should be undertaken, and training materials on data and its users should be provided, with targeted training provided to key staff tiers.	5.1.2 Training plan to developed in response to planned care training needs assessment	Dylan Roberts, Chief Digital and Information Officer	31/12/2024	The training needs analysis did not identify the need for specific training provision other than support in accessing data. This requirement was met as part of the launch of the redeveloped IRIS information portal in June 2025. Analytical methodologies used to inform and monitor planned care programmes are introduced and explained through programme meetings and local follow up discussions. The DI&I team will continue to work closely with the Planned Care major change programme and operational teams to identify and act on training needs.	Outside scope of IA review
1397	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 5: Data literacy (Operation)	5.1.3 The data literacy assessment should be undertaken, and training materials on data and its users should be provided, with targeted training provided to key staff tiers	5.1.3 Baseline assessment of UEC data maturity (replicating process undertaken for planned care)	Dylan Roberts, Chief Digital and Information Officer	31/01/2025	Initial UEC baseline assessment undertaken. Work with UEC programme underway to identify next steps to increase maturity.	Outside scope of IA review
1398	Intelligence Led Organisation	2024	n/a	Reasonable	High	Matter Arising 5: Data literacy (Operation)	5.1.4 The data literacy assessment should be undertaken, and training materials on data and its users should be provided, with targeted training provided to key staff tiers.	5.1.4 Data quality, reporting flows and purposes video to be created for awareness of data processes and important of data quality to be shared as part of system training and general data quality awareness	Dylan Roberts, Chief Digital and Information Officer	31/01/2025	Series of three videos produced describing flows and uses of data. Agreement in place for these to be included in the mandatory data element of the Betsi Foundations learning programme. Part 1: Data Flows 1 - Data Input and Data Quality.mp4 Part 2: Data Flows - Systems and Data Warehouse.mp4 Part 3: Data Flows - Reporting and Data Uses.mp4	Outside scope of IA review
1410	Charitable Funds - 2024	2024	n/a	Reasonable	High	Matter Arising 3: Strategy (Design)	3.1a) Charitable Support Operational Plan to be submitted to the Charitable Funds Committee and Board of Trustees for approval.	3.1a) Operational Plan to be approved by the Charitable Funds Committee on the 12th November 2024	Russell Caldicott, Executive Director of Finance	31/01/2025	Operational Plan included in 12/11/24 CFC agenda	Outside scope of IA review
1411	Charitable Funds - 2024	2024	n/a	Reasonable	High	Matter Arising 3: Strategy (Design)	3.1b) Charitable Support Operational Plan to be submitted to the Charitable Funds Committee and Board of Trustees for approval.	3.1b) Operational Plan to be ratified by the Board at the January 2025 Trustee meeting.	Russell Caldicott, Executive Director of Finance	31/01/2025	Verbal presentation of the Charity's Strategy and Operational plan provided at the January Board meeting (31/01/25 Trustee meeting minutes).	Outside scope of IA review
1416	Charitable Funds - 2024	2024	n/a	Reasonable	High	Matter Arising 5: Expenditure (Operation)	5.1a) Charitable funds expenditure approval arrangements to be reviewed to ensure compliance with Committee Terms of Reference and Health Board Scheme of Reservation and Delegation is maintained. Any amendment to the Charitable Funds Committee's responsibilities and / or delegated authority to be approved by the Board of Trustees.	5.1a) Committee Terms of Reference has been reviewed and approved by the Executive. A CFC Grant meeting will occur every six weeks to undertake an in depth consideration of the grant applications. The sessions will be minuted and will be presented at the Public session with Terms of Reference being recommended for approval at the Charitable Funds Committee on the 12th November 24 and Board of Trustees for approval at the January 2025 Trustee	Russell Caldicott, Executive Director of Finance	31/01/2025	TOR approved	Outside scope of IA review
1417	Charitable Funds - 2024	2024	n/a	Reasonable	High	Matter Arising 5: Expenditure (Operation)	5.2a) Charity governance and supporting documents to be updated and aligned to ensure consistency	5.2a) List of Charity governance documentation to be reviewed and submitted to the Charitable Funds Committee with review dates for information	Russell Caldicott, Executive Director of Finance	31/01/2025	Policies and Procedures review included on Cycle of Business, and policies added to the workplan as required	Outside scope of IA review
1418	Charitable Funds - 2024	2024	n/a	Reasonable	High	Matter Arising 5: Expenditure (Operation)	5.2b) Charity governance and supporting documents to be updated and aligned to ensure consistency	5.2b) All supporting documents that require updating are to be resubmitted to the Charitable Funds Committee for approval	Russell Caldicott, Executive Director of Finance	31/01/2025	Policies and Procedures review included on Cycle of Business, and policies added to the workplan as required	Outside scope of IA review
1479	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.	R2.1: 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.	R1.1: Review and remove all non-ICT staff from access rights.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026	The access group has been reviewed and all non-ICT staff who have no business case have been reviewed. Staff with a valid case, for example Estates have been retained in the group.	Outside scope of IA review
1480	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.	R2.2: 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.	R2.2: Realign ICT to be responsible for adding permissions to access rights from the Estates Team.	Dylan Roberts, Chief Digital and Information Officer	30/09/2025	ICT have taken up responsibility for managing access to the relevant door.	Outside scope of IA review
1481	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.	R2.3: 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.	R2.3: Reminder to be issued to all ICT to accompany visitors whilst on ICT secure sites.	Dylan Roberts, Chief Digital and Information Officer	30/09/2025	SOP developed. Reminder sent to all ICT staff	Outside scope of IA review

1483	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.	R2.5: 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.	R2.5: Review the provision of CCTV at the entry points to ICT infrastructure and work areas.	Dylan Roberts, Chief Digital and Information Officer	30/09/2025	Review of CCTV provision has been carried out.	Outside scope of IA review
1500	Establishment Control	2025	Reasonable	Reasonable	Medium	Objective 2: Establishment / budgets are communicated to operational areas and regularly reviewed by management.	4. Budget manager training Based on our sample testing, there is poor uptake of E Learning mandatory training by budget managers.	4. Finance will: Review the training that is mandated and ensure it is aligned to the correct budget managers. Review the numerous training packages available for budget managers including the current ESR E-Learning package and will look to streamline, mandate and monitor a suitable training offering and will email out to all budget holders to remind them of the need for them to undertake mandatory budget holder training.	Russell Caldicott, Executive Director of Finance	31/03/2025	The committee is requested to consider if this can closed as this is superseded by audit ID 1596	Outside scope of IA review
1504	Job Evaluation	2025	Not rated	Reasonable	Medium	Objective 1: The Health Board has appropriate policies and procedures in place, which set out the job evaluation process and promote fairness, consistency and equality for all staff.	1. Review of Health Board procedures on publication of new Handbook editions and changes to process Current Health Board procedures are not reflective of the updated eighth edition handbook or the revised procedure instigated on 17 October 2024.	1. The new all Wales JE Policy was released in December 2024 which will supersede the current BCU WP26 JE procedures. As part of implementing the new policy, updated governance protocols will be incorporated in the associated operating procedures.	Jason Brannan, Deputy Director of People	31/05/2025	The new JE policy and process was launched on 1st August 2025.	Outside scope of IA review
1505	Job Evaluation	2025	Not rated	Not completed	High	Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy	2. Scheme of Reservation and Delegation (SoRD) compliance The Health Board's governing SoRD document includes Delegated Matter 10e, concerning requests for upgrading or regrading which is delegated to the Service Director. Job Evaluation procedures are not aligned with this requirement and permit submission of review/re-banding requests from a line manager and head of service, breaching the SoRD. There is no control to ensure appropriate segregation in line manager and head of service approval. We identified 285 (40%) of the 714 Re-band/Review submissions from 2019 to 18/11/24 were undertaken by the line manager who is also the head of service.	2. Under the new all Wales JE policy, procedures will be updated to incorporate an evaluation of banding reviews prior to them being submitted to the JE team. This new pre-evaluation sign off will include the service director to meet the requirements on the SORD.	Jason Brannan, Deputy Director of People	31/05/2025	The new JE policy and process was launched on 1st August 2025. This now incorporates DMT approval for all banding reviews prior to being submitted to job evaluation.	Outside scope of IA review
1506	Job Evaluation	2025	Not rated	Not completed	High	Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy	3. Computer Aided Job Evaluation (CAJE) referenced Job Descriptions included in all vacancy adverts We found two of the five new posts that were advertised included the correct job description with the CAJE reference and date noted. We broadened our review to current live posts advertised on TRAC (as of 28 November 2024) and found an instance where the job description had no CAJE reference - we could not verify if it was the correct band and description for the advertised role.	3. A communications notice will be issued to all recruiting managers that the CAJE reference is a mandatory field in the Establishment Control system. Subsequent sample audits of JDs will take place between the JE and EC team with compliance monitoring reported as part of the routine updates to Local Partnership Forum (LPF).	Jason Brannan, Deputy Director of People	30/06/2025	Routine audit testing has commenced which looks at live vacancies and whether the JD has a valid CAJE ref. The findings of the audits are reported to Local Partnership Forum	Outside scope of IA review

1507	Job Evaluation	2025	Not rated	Not completed	High	Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy	4. Conflicts of Interest in Job Matching Panels We sought to evidence that matching panels were not subject to conflicts of interest or that consistency checkers were not part of the matching panel to ensure independence in the process. This information has not been provided for us to review.	4. As per management response to item 4.6: Due to current limited resource, there are instances in recent months whereby the same panel members have undertaken a JD review and also participated in consistency checking. A report of the number of instances where this has happened will be reported to LPF. To address the issue recurring, the JE team will aim to avoid holding any consistency checking panels without full independent members. Any consequent delays in the JE processing times will be reported to the JEPS steering going and Local Partnership Forum. If, in an exceptional circumstance, the same member has needed to sit on the matching and consistency panel, a declaration of interest will be recorded and reported to LPF.	Jason Brannan, Deputy Director of People	28/02/2025	Email from Jason Brannan approving the statement provided in May and also the confirmation that LPF will be the oversight group for any reported exceptions. Also LPF report from February 2025 confirms the reporting process.	Outside scope of IA review
1508	Job Evaluation	2025	Not rated	Not completed	Medium	Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy	5. Panel outcomes are actioned in a timely manner Following a review of recorded outcomes for our sample, we found that five of fifteen (33%) had not been actioned by management at the time of our review and were advised that the delays had been due to, in the main, the need to progress through establishment control and virements for the funding. We found the delays varied between two and seven months from the date of outcome and were still to be actioned. Establishment Control procedure has no reference to any requirement for a matched re-banding/review to go through a further set of controls, once it has been matched and consistency panel checked.	5. As part of implementing the new all Wales policy, incorporating a pre-evaluation panel, the funding requirements will be identified prior to a banding review taking place. As such, there will be no requirement to withhold any alterations to banding/salary once the JE evaluation has taken place.	Jason Brannan, Deputy Director of People	31/05/2025	The new JE policy and process was launched on 1st August 2025. This now incorporates DMT approval for all banding reviews prior to being submitted to job evaluation. The manager is now asked to submit the SMA form directly to payroll once the JE outcome is given, thus avoiding any delays to pay uplifts.	Outside scope of IA review
1510	Job Evaluation	2025	Not rated	Not completed	High	Objective 4: Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook	6. Consistency Checking compliance Requirements for consistency checking are clear in both the Handbook and Health Board procedure, however compliance with expected control cannot be verified due to the evidence required to undertake the review not being provided.	6. As per management response to item 4.4: Due to current limited resource, there are instances in recent months whereby the same panel members have undertaken a JD review and also participated in consistency checking. A report of the number of instances where this has happened will be reported to LPF. To address the issue recurring, the JE team will aim to avoid holding any consistency checking panels without full independent members. Any consequent delays in the JE processing times will be reported to the JEPS steering going and Local Partnership Forum. If, in an exceptional circumstance, the same member has needed to sit on the matching and consistency panel, a declaration of interest will be recorded and reported to LPF.	Jason Brannan, Deputy Director of People	28/02/2025	Agreed with Internal Audit the management response to this would be the same as number 4. Attached email from Jason Brannan approving the statement provided in May and also the confirmation that LPF will be the oversight group for any reported exceptions. Also evidence of the LPF report from February 2025 that confirms the reporting process.	Outside scope of IA review
1512	Transformation & Improvement	2025	Reasonable	Reasonable	Medium	Objective 2: The Team is providing their services to areas across the Health Board and promote use of transformation resource.	2. Resources Feedback received from services included observations/comment concerning limited access to a transformation resource due to Health Board's demand on the Transformation and Improvement team in other areas.	2. Implement regular review and re-prioritisation of the change portfolio, with executive approval and ensure resource is allocated in line with the executive approval.	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	30/06/2025	Remaining Major Change Programme Director posts now appointed to, and all 4 reporting to the Executive Director of Transformation and Planning. Allocation of team to the priority programmes now agreed with the CEO. Strategic Planning and Service Change Group (a sub group of Execs chaired by the CEO) has now met a number of times and is driving forward key strands of work across the directorate with reporting mechanisms now in place for Key Programmes and Challenged Services.	Outside scope of IA review

1546	Standing Financial Instructions - Procurement	2025	Reasonable	Reasonable	Medium	Objective 2: There is evidence to support delivery of agreed actions, and, where applicable, changes have been embedded into processes.	2. Evidence of Delivery: We were unable to verify implementation / completion of the following recommended actions: • R004 - Implementation of all Ernst & Young (E&Y) report recommendations. Update states that many of the recommendations from the E&Y report were included as separate actions in the Independent Review recommendations. Whilst noting several EY actions have been addressed as they were included in the report, the report stated that management should address the specific recommendations from EY. We have not been able to evidence closure of some recommendations such as contract limits reviewed / contracts approved in line with limits. • R005 – Single Tender Waiver (STW) / Single Quote Waiver (SQW) compliance with Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SoRD) – STW / SQW source data was not provided for review. • R008 – Signing of contracts in accordance with Standing Financial Instructions (SFI) and SoRD – source contract data was not provided for review.	2. Following the Ernst & Young report, the specification for the Procurement and Contracting Internal Audit review, carried out in 2023, was agreed with Welsh Government and was used to inform necessary improvements to the control environment. This included a review and update of the Scheme of Delegation for the Health Board. Contract management is controlled in accordance with the Scheme of Delegation. Controls and actions have been reviewed by Internal Audit since implementation. The Single Tender Waiver (STW) / Single Quote Waiver (SQW) data was emailed to Internal Audit but not received by them and it is unclear as to why the email did not arrive. Two separate emails providing information requested by Internal Audit were sent within ten minutes of each other, one email containing Purchase Order (PO) data (see finding 4 below) and one containing the STW/SQW data. The email containing the PO data was received but not the email containing the STW/SQW data. Internal Audit requested a full listing of contracts from NHS Wales Shared Services Partnership (NWSSP). A sample of contracts for the Health board was provided to Internal Audit but not a full listing of contract data	Russell Caldicott, Executive Director of Finance	16/04/2025	No further action required. Action to be closed	Outside scope of IA review
1547	Standing Financial Instructions - Procurement	2025	Reasonable	Reasonable	Medium	Objective 2: There is evidence to support delivery of agreed actions, and, where applicable, changes have been embedded into processes.	3. Conformance Reports We confirmed that quarterly Conformance Reports were submitted to the Audit Committee during January 2024 - March 2025. However, the Audit Committee Cycle of Business specifies that the Financial Conformance report (including review of losses & special payments, review of risks and controls and reporting of any Standing Orders (SO) breaches), and Details of Breaches of SFIs, Scheme of Delegation and SOs, should be presented at each Audit Committee.	3. The Audit Committee Cycle of Business is to be updated to specify that a Financial Conformance Report is produced on a quarterly basis and will be presented at Audit Committee meetings as appropriate in the meeting following the quarter end and completion of the report	Russell Caldicott, Executive Director of Finance	16/04/2025	Reports now as per cycle of business are being reported to the Audit Committee.	Outside scope of IA review
1548	Standing Financial Instructions - Procurement	2025	Reasonable	Reasonable	Medium	Objective 2: There is evidence to support delivery of agreed actions, and, where applicable, changes have been embedded into processes.	4. Issue of Purchase Orders The review of the one hundred and twenty-three thousand, six hundred and fifty-three (123,653) Purchase Orders (POs) issued by the Health Board for April to December 2024 inclusive noted a small number that were recorded in the 'PO Issued to' column as either having #N/A or -. The summary of POs are as follows:	4. Out of the 1,596 Purchase Orders (PO) noted, 1,257 (79%) of these related to three suppliers (NHS Supply Chain, a stationery supplier and pharmacy supplier) where there are automated systems in place for the transferring of PO data. Other PO data did not consistently contain email addresses for the suppliers. BCUHB to work with NHS Wales Shared Services Partnership (NWSSP) Procurement Services to update email addresses where necessary and seek regular assurance via quarterly reports and the annual assurance report	Russell Caldicott, Executive Director of Finance	16/04/2025	Quarterly reports are presented by NWSSP to the PFIG meetings.	Outside scope of IA review
1549	Standing Financial Instructions - Procurement	2025	Reasonable	Reasonable	Medium	Objective 2: There is evidence to support delivery of agreed actions, and, where applicable, changes have been embedded into processes.	5. Delegated Limits We reviewed the Oracle approver data for the 50 members of Health Board staff with the highest approval limit and sought to reconcile to the limits specified in the Scheme of Reservation and Delegation (SoRD). Whilst approval limits were consistent with the SoRD, we noted the following limitations: • Not all senior management posts are detailed in the SoRD (e.g. Chief Pharmacist, DGM Cancer Services, Associate Director DSCS). • It is not always clear which posts / positions are equivalent to those specified in the SoRD (e.g. Head of Capital Development, Consultant Oral and Maxillofacial Surgery, Director/Assistant North Wales Dental	5. The Scheme of Delegation (SoRD) for the Health Board is currently being reviewed and updated. There have been a number of changes in senior management posts since the last version of the SoRD was approved in November 2023 which will be reflected in the updated SoRD. Chief Finance Officers (CFO) are to ensure ongoing and regular reviews are undertaken of 'Operational Schemes of Delegation' for their areas / divisions / departments to include new and additional posts and positions, and changes to posts and positions, within their service areas.	Russell Caldicott, Executive Director of Finance	16/04/2025	The revised SoRD was approved by Board on 25 September. The new SoRD includes the introduction of a 'tier' for financial delegations, this is to ensure that there is consistency in terms of the levels of delegations across the organisation.	Outside scope of IA review

1556	Partnerships, Engagement and Communication	2025	Limited	Reasonable	Medium	Objective 1: There are effective processes in place to monitor, manage and support implementation of the key elements stated in the Strategy, Health Board Three Year Plan (partnership and engagement references) and recommendations from the independent report.	1. Outstanding actions Not all improvement actions were delivered / implemented within the specified timescales (noting that no delivery deadlines were set for the Listening to Citizens Independent Review recommendations). March 2025 updates show the following completion rates: • PEC Strategy (2022-25) – 91% • Annual Delivery Plan – 78% • Listening to Citizens Independent Review – 58% Management advised that all outstanding actions will be consolidated into a single delivery plan for the 2025-26 financial year.	1. Consolidation and Acceleration of Outstanding Improvement Actions (2025-26) To ensure transparency, accountability and momentum, all outstanding improvement actions from the programmes will be reviewed and consolidated into a single, time-bound delivery plan for 2025–26: This consolidated plan will: • Clearly identify each outstanding action and its origin • Set realistic and specific delivery deadlines for each item • Assign clear ownership and accountability • Be reviewed regularly through PEC governance structures, with progress updates reported quarterly Target Implementation Date: The consolidated plan will be finalised and approved by the end of Q1 2025–26 (June 2025).	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/06/2025	Complete - see consolidated plan	Outside scope of IA review
1584	Grievance Management	2025	Reasonable	Reasonable	Medium	Objective 2: Formal grievances are recorded, monitored, and reported within the Health Board. Where delays are identified, these are escalated / actioned as required.	1. Reporting There is regular reporting on employee relations, however this reflects disciplinary data and does not include information on Respect & Resolution (R&R) / grievance cases. Whilst this information is reviewed, inclusion of this data within standard People reports (to local meetings, and the People & Culture Committee) i.e. number of cases, reasons, timescales, would provide more insight into all employee relations issues.	1. Work to improve case referencing to easily identify the type of case. Employee Relations reporting to include R&R cases as well as disciplinary cases.	Jason Brannan, Deputy Director of People	31/08/2025	Updated ER Cases report now contains data regarding Respect & Resolution Cases and will be included in report to People & Culture Committee.	Outside scope of IA review
1598	Duty of Quality	2025	Reasonable	Reasonable	Medium	Objective 2: There are clear policies and procedures covering the requirements of the Duty and the related Welsh Government guidance.	1. Policies The Quality Regulatory Policy is designed to ensure compliance with the Duty of Quality by defining roles and responsibilities. Staff currently do not have access to this document as it is in draft and may be unaware of their responsibilities around the Duty of Quality.	1. Management will take the Quality Regulatory Policy through the Health Board's governance process to finalise and will then make it available to all staff via SharePoint.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025	The policy has been ratified by the Health Board and is now available across the organisation.	Outside scope of IA review
1599	Duty of Quality	2025	Reasonable	Reasonable	Medium	Objective 3: There is Board-wide training and ongoing support to help staff meet the requirements of the Duty.	2. Training Training around the Duty of Quality is not mandatory however, the Duty stipulates that training and support requirements will be built over time, through the work of QMS. The Health Board aim to complete a training matrix and then decide and track staff who will be required to complete the training and overall training figures. Currently the matrix and tracking of training completion do not take place.	2. Management will undertake a training needs analysis and identify the scope of training required. Training completion rates will then be tracked and reported.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025	This action has progressed and the Quality Team are just awaiting confirmation from ESR training Data Team that this request for regular Data and SPOC to liaise and receive data has been actioned.	Outside scope of IA review
1600	Duty of Quality	2025	Reasonable	Reasonable	Medium	Objective 4: The Health Board's Quality Management System (QMS) supports compliance with the Duty.	3. QMS The QMS is to be piloted in eight at risk services, but a help guide is not yet available for these services to review to assist with using the QMS. Without this staff may be unaware of what functionalities the system offers, and each service may use it differently creating inconsistencies.	3. Management will create a separate help guide detailing a step by-step process of how to use the QMS and where to go for additional help.	Angela Wood, Executive Director of Nursing and Midwifery	30/08/2025	Guide and this is now Operational in the QMS digital assessment app for users to access.	Outside scope of IA review

AUDIT WALES - RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE APPROVAL

ID	Report Title	Year	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementat ion date	Last update
0396	Structured Assessment 2023	2023	Transparency of board and committee business	R2: The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business	R2: Agreed. The Director of Corporate Governance will review the current process and the Standing Operating Procedure for Board and Committee meeting and agree this with the Board.	Pam Wenger, Director of Corporate Governance	31/05/2024	It is now normal practice to upload Minutes within two days of approval at the meeting. When information is uploaded onto the website, there is no way to capture the date/time it was uploaded. Screenshot of website provided as evidence that minutes are on the website.
1454	Structured Assessment 2024	2024	Recommendation 3	R3. When the Board reports against decisions taken in private session or via Chair’s Actions, it should ensure that, where relevant, the cost implications of decisions are clearly reported.	R3: The Health Board has strengthened the reporting of the decisions made in private during 2024/24 as previously this was a verbal update. Key actions include: Reporting of financial implications as part of the decision-making process, unless of course, in matters relating to individuals and therefore an exemption would apply.	Pam Wenger, Director of Corporate Governance	31/01/2025	Completed. Included in the Corporate Governance Report to the Board
1455	Structured Assessment 2024	2024	Recommendation 4	R4. The Health Board should ensure review of minutes is a standing item on the agenda of each Remuneration Committee meeting (including additional meetings) to ensure the Board has access to an accurate and timely description of the decisions taken.	R4: The Health Board has held a number of additional Remuneration Committee’s during 2024 to progress the appointment of Executive Director posts. Key actions include: Ensuring that where minutes are available then these will be brought to the next available meeting as per the cycle of business.	Pam Wenger, Director of Corporate Governance	31/01/2025	Completed – current practice
1458	Structured Assessment 2024	2024	Recommendation 6	R6. As part of the development of a meaningful Board Assurance Framework, the Health Board should provide Board members with further supporting detail on its strategic objectives to clarify what the objectives are seeking to achieve.	R6: The Health Board has reviewed the Board Assurance Framework during 2024/25 which will be aligned to the Strategic Objectives for the 2025/26 Plan once agreed by the Board. Action: To provide additional detail as part of the development of the IMTP for 2025/26	Pam Wenger, Director of Corporate Governance	31/01/2025	The Board Assurance Framework was approved by the Board in January 2025 and is linked to the strategic objectives. The Planning team are currently building the BAF in the portal so milestones will auto populate from plans to ensure it aligns fully with the final approved plan and next years plans going forward.
1459	Structured Assessment 2024	2024	Recommendation 7	R7. The Health Board should ensure that audit reports that are relevant to the remit of other Board committees are received and discussed by those committees, including periodic updates against any associated recommendations.	R7: The Health Board is considering the approach to dealing with reports from external regulatory bodies as part of the IMTP for 2025/26. However, there has been progress during 2024/25 which has included progress against external audits at committees, and it recognises there is more to do in this area. Action: The governance process on reviewing of audit reports will be developed further to ensure that audit reports are considered at the relevant	Pam Wenger, Director of Corporate Governance	30/04/2025	Audit reports are considered by the appropriate committee, eg, Job Planning, Clinical Audit reported to the QSE Committee; Operating Model audit report reported directly to Board and through the People and Culture Committee; Health and Safety audit report through the People and Culture Committee.

1460	Structured Assessment 2024	2024	Recommendation 8	R8. The Health Board should ensure that it appropriately engages with Board members and Regional Partnership Board partners in the process of developing future Integrated Medium Term Plans or Annual Plans.	R8: The Health Board has reviewed the approach and membership at the RPB during 2024/25. Action: • The Health Board will ensure that it engages with the RPB as part of the development of the IMTP and other corporate plans such as the development of the Organisational Strategy.	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2025	There is an improved process in place for the development of this year's IMTP, having taken learning from previous years and the Special Measures Independent review of Planning. This has been applied to both Board Member and Partner engagement, which has resulted in both happening more frequently and earlier in the process. Board Members have been engaged multiple times through informal and formal Board meetings and through PPHP and PFIG as lead Board Committees for the IMTP and Financial plans respectively. It is also the case that all Board Committees have contributed to the plan through their cycles of business aligning to the IMTP and in particular when doing deep dives on specific topics such as individual Challenged Services. They have also been engaged along with Partners through SRG, LPF and HPF. Finally the RPB has been involved in contributing to the IMTP, completing a reasonable cross section of stakeholder and partner engagement. It is felt that this evidences that the recommendations made have been met.
1461	Structured Assessment 2024	2024	Recommendation 9	R9. Where the Health Board needs to carry forward actions from one Annual Plan to the next, it should ensure that progress reports are clear on which actions have been retired or carried forward and provide clear and realistic milestones for those actions.	R9: The Health Board has made progress during 2024/25 in the reporting of the progress against the Annual Plan, further work will be continued into 2025/26. Actions: The monitoring report will be strengthen to address the recommendation including clear milestones and actions.	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	30/04/2025	A full change control exercise has taken place for the milestones within the 24/25 plan which did not complete in year. This has resulted in a clear outcome with milestones either retired, added to the 25/26 plan or mapped across to existing priorities within the IMTP. This has all been presented to the May Board for approval.
1462	Review of Cost Savings Arrangements	2024	Recommendation 1.1	R1.1: The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.1: Demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered.	R1.1 The base budgets have been developed from determination of the underlying position, unavoidable cost pressures and additional developments supported through a process of allocation by the Executive and then wider Health Board. This will be enhanced for 2025/26 through use of Value Based Healthcare (Value & sustainability) work that will include articulation productivity and efficiency by speciality.	Russell Caldicott, Executive Director of Finance	31/10/2025	The 25/26 budget was set based upon information relating to the underlying position, as provided by the finance leads for individual IHCs. The information contained detail around cost pressures, and these were considered on the basis of avoidable and unavoidable, with some difficult decisions needing to be made regarding what could and couldn't be funded to enable the setting of a balanced budget. Some of the pressures that haven't been funded are identified as a risk, and these are being managed. In addition some developments are still under consideration, with funding remaining in reserves for the short term. The prioritisation of these funds is now being carried out by the planning team and is scheduled to conclude shortly. The budget setting details were articulated in a presentation

1465		2024	Recommendation 2.1	R2.1: The Health Board should strengthen its approach to the identification and delivery of savings by: 2.1: Identifying viable savings schemes to meet the Health Board’s overall savings target earlier in the financial planning cycle.	R2.1 The Health Board identified the 2024/25 full year ask of £48m by month 7. This gives greater opportunity to identify opportunities and turn those into savings green rated schemes prior to commencement of the 2025/26 financial year. To support identification and delivery of savings, a Director of Value and Sustainability will co-ordinate identification of opportunities through to delivery of savings, an Executive lead identified for each of the five V&S national themes. The all-Wales Vault, Informatics data, costing data, all Wales V&S Group Reports support the Executive officers in identification of opportunities. Each Executive held accountable at the Monthly Integrated Performance – Executive Delivery Group for progress, which is chaired by Chief Executive. The Divisional Directors also held accountable within this forum for ~~delegated savings target performance~~.	Russell Caldicott, Executive Director of Finance	N/A	The Director of V & S has set up a governance structure (see attached Governance Structure). An Executive lead has been assigned to each workstream (see attached Programme structure). All sources of information relating to emerging opportunities are reviewed and shared on a regular basis to ensure every opportunity is considered. Executives are asked to provide updates at IPEDG (see Programme board notes 07.07.25) and Divisional Directors are clear on accountability (see 2025-26 accountability agreement template which has been sent to all budget managers). The Committee is asked to consider if this action can now be closed.
1466	Review of Cost Savings Arrangements	2024	Recommendation 2.2	R2.2: The Health Board should strengthen its approach to the identification and delivery of savings by: R2.2: Taking earlier remedial action to bring under-performing saving schemes back on track.	R2.2 The guidance will be amended to include the reporting of underperforming schemes to the Integrated Performance – Executive Delivery Group. The report will include the supporting explanations and the action to be taken to either recover or mitigate the performance.	Russell Caldicott, Executive Director of Finance	31/03/2025	The guidance reflects the need to show clearly any slippage on delivery of schemes. (Copy of the guidance attached) and the PFIG/HB reports include that information on a scheme by scheme basis (Copy of the month 2 PFIG report attached). In addition to this the IPEDG and Programme board undertake deep dives on individual themes and leads are asked to provide details of blockages and challenges to enable Executives to support the removal of barriers. Attached is an example of a highlight report presented at V & S Programme board which shows delivery against submitted plans. Regular meetings are also held with V & S leads to discuss progress and challenges on a local level. The Committee is asked to consider if this action can now be closed.
1471	Review of Cost Savings Arrangements	2024	Recommendation 3.2	R3.2: When updating its savings guidance, the Health Board should ensure: R3.2: That the guidance reflects the new savings approach based around its Value and Sustainability Board framework.	R3.2 The guidance refers to the Value and Sustainability categories. However, this will be expanded to include references to the newly developed Value and Sustainability Framework.	Russell Caldicott, Executive Director of Finance	31/03/2025	The guidance has been updated to include reference to the V & S framework.
1517	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 5. Seek options for Home First to be able to access Council WCCIS system in the East. (OWNER: IHC Director - East)	Imran Devji, Interim Chief Operating Officer	31/10/2024	Currently in the East Region Health Board staff do have access to Wrexham and Flintshire Local Authority information as part of the Integrated Team approach. WCCIS is in the process of being replaced nationally and so an alternative solution will be
1518	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 6. Revisit schedule of multi-agency meetings to verify that those contact points achieve a shared position re updates on discharge planning as part of the ongoing Home First Review in the East (OWNER: IHC Director - East)	Imran Devji, Interim Chief Operating Officer	31/10/2024	A review of Home First was undertaken during November 2024, in collaboration with Wrexham and Flintshire Local Authorities and was signed off by the East Senior Leadership Team. This included reviewing and updating all Standard Operating Procedures and Finances to ensure they remained fit for purpose. Please see attached standard operating procedures.

1519	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 7. Consider how the use of STREAM is consistently updated with potential for local authority access. (OWNER: Acting Assistant Director of Care Homes Support)	Imran Devji, Interim Chief Operating Officer	31/10/2024	Currently focussing on embedding the use and consistency of use of STREAM in the Health Setting. No discussion with Local Authority colleagues taking place at the moment. Please refer to the terms of reference for the Improvement Group and an example of the minutes.

Name	Review Date	Responsible Director	Update as at 12/01/2026
ISU03 - Volunteering Policy - V0.1.pdf	12/01/2017	Executive Director of Workforce and Organisational Development	This is for reassignment to Charities and Volunteers. Policy Team awaiting written confirmation from accountable exec team members for this to be re-assigned
TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	01/05/2017	Executive Medical Director	This should be a procedure. Policy is currently being updated by the national IPFR group. Requested timescales so we can progress request removal of BCU document if imminent
PTR02 - Claims Management Policy.pdf	05/06/2017	Director of Corporate Governance	Due to operational and workload pressures, work has progressed slower than planned. The new document will be finalised by 31/03/2026.
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	Being reviewed by W&OD remove from OMD?
MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	Being reviewed by W&OD remove from OMD?
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	20/10/2017	Executive Medical Director	Being reviewed by W&OD remove from OMD?
WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	01/01/2018	Executive Director of Workforce and Organisational Development	Out for consultation with People Services.
NHS Wales Social Media Policy - V0.10.pdf	07/01/2018	Executive Director of Workforce and Organisational Development	This is for reassignment to Information Governance. Policy Team awaiting written confirmation from accountable exec team members for this to be re-assigned
All Wales Email Use Policy - V2.pdf	26/06/2018	Chief Digital Information Officer	Awaiting national review and approval
RD04 - NHS R&D Finance Policy - V1.0.pdf	20/07/2019	Executive Medical Director	Not changed as follow All Wales SOP.
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2019	Chief Operating Officer	No update received.
WP29 - BCU Relocation Expenses Policy V0.3.pdf	05/12/2019	Executive Director of Workforce and Organisational Development	NHS Wales Policy imminent.
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	01/07/2020	Executive Director of Allied Health Professions and Health Science	Procedure returned following consultation with author for review. This procedure will change title to become Controlled Access & Egress for Inpatient Wards.
All Wales Policy on Insurance, NHS Indemnity & related Risk Management for Potential Losses & Special Payments.pdf	11/09/2020	Executive Director of Finance	No update received.
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	01/03/2021	Executive Medical Director	Approved by SACT Governance group . Document on agenda for MPPG on 21.1.26
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	01/05/2021	Executive Medical Director	Liaising with estates as they have an overarching medical gas policy that encompasses very similar things especially in relation to medical gas pipeline staff responsibilities. Work ongoing to review whether there is a need for MM37
BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf	01/07/2021	Director of Corporate Governance	This will be merged into PTR02.
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	01/09/2021	Executive Medical Director	Awaiting updated listed of INNU from WG due in next few weeks then will update local policy.
WP11 - NHS Wales Managing Attendance at Work Policy - Cymraeg.pdf	01/10/2021	Executive Director of Workforce and Organisational Development	New NHS Wales Policy due in Summer 2026
WP11 - NHS Wales Managing Attendance at Work Policy - V0.1.pdf	01/10/2021	Executive Director of Workforce and Organisational Development	New NHS Wales Policy due in Summer 2026
ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	01/04/2022	Director of Environment and Estates	No update received.
MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	01/05/2022	Executive Director of Allied Health Professions and Health Science	In December 2025 amendments were sent to the Author / Policy Lead to be addressed prior to further QA checks be completed and final approval sought at the Executive Policy Oversight Group. No new developments to date
MM02 - Injectable Medicines Policy.pdf	08/07/2022	Executive Medical Director	Review is progressing but still have some outstanding questions and will need to revisit BCU wide consultation, aiming for early 2026.

RD03 - Policy for Intellectual Property - V2.pdf	01/08/2022	Executive Medical Director	RD03 Been working under the assumption that the Welsh Government will soon finalise their approach. Therefore, we will be waiting for guidance to be issued via a Welsh Health Circular that will enable us to implement updates to our Local BCUHB IP policy, as they will be providing templates for us to localise for BCUHB. With Innovation Team
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	01/12/2022	Chief Operating Officer	No update received.
Polisi Clinigol DNACPR Ar Gyfer Oedolion Yng Nghymru - V4.pdf	01/12/2022	Chief Operating Officer	No update received.
All Wales Information Governance Policy - V2.pdf	13/01/2023	Chief Digital Information Officer	Awaiting national review and approval
All Wales Information Security Policy - V2.pdf	13/01/2023	Chief Digital Information Officer	Awaiting national review and approval
All Wales Internet Use Policy - V3.pdf	13/01/2023	Chief Digital Information Officer	Awaiting national review and approval
ES03 - Waste Management Policy - V5.pdf	01/09/2023	Director of Environment and Estates	No update received.
MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	01/10/2023	Executive Director of Allied Health Professions and Health Science	In December 2025 amendments were sent to the Author / Policy Lead to be addressed prior to further QA checks be completed and final approval sought at the Executive Policy Oversight Group. No new developments to date
MM01 - BCUHB Medicines Policy.pdf	31/12/2023	Executive Medical Director	The review is part of a significant ongoing workstream. The approach involves dividing each chapter into separate procedure documents. The overarching policy will ultimately be a concise, high-level document (around three pages) summarising the legislation underpinning each procedure. Currently published: MM01 a MM01a - BCUHB Procedure For The Safe Custody Management and Use for Controlled Drugs MM01 b MM01b - BCUHB Procedure for the Safe Storage of Medicines in Clinical Areas Each time we publish a new document we remove the chapter from MM01. We are currently working on the prescribing section, MM01c. sent for BCU wide consultation. The CD Incident Management Sop has been approved by EQDG on 8.12 , submitted to BCU Policies for upload. MM01 remains in use until all chapters have been replaced. The front cover that the document is kept updated—the most recent minor amendment was made on 15.09.25. MM01 - BCUHB Medicines Policy .
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	15/01/2024	Executive Director of Allied Health Professions and Health Science	Endorsed at PSG 16/12/25 by Chair, following EqIA amendments. For EQDG approval Jan 26
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	01/03/2024	Executive Director of Allied Health Professions and Health Science	Draft out for final Consultation
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	01/08/2024	Chief Operating Officer	No update received.
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	15/08/2024	Executive Director of Finance	No update received.
WP69 - Employer Pension Contributions – Alternative Payment Policy.pdf	01/03/2025	Executive Director of Workforce and Organisational Development	Due in Policy Group January 2026
ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf	08/03/2025	Director of Environment and Estates	No update received.
HS23 - CCTV and Body Worn Video (BWV) Policy - V1.0.pdf	15/03/2025	Executive Director of Workforce and Organisational Development	For H&S. Policy Team awaiting written confirmation from accountable exec team members for this to be re-assigned
MM03 - Procedure for Supplementary (SP) and Independent (IP) Prescribers (1).pdf	01/04/2025	Executive Medical Director	This should be procedure not policy. Updated periodically and noted on front cover. Document will be replaced by All Wales NMP document (currently in discussion how to progress this) and new SOP for prescribers to register with the BCU NMP database once new digital process launched as per WG HC for Standards for Competency Assurance of Non-Medical Prescribers in Wales. Due date 31.3.26

MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf	29/04/2025	Executive Director of Allied Health Professions and Health Science	No update received.
ES02 - Policy for the Management of Safe Water Systems.pdf	10/05/2025	Director of Environment and Estates	No update received.
RD02 - Policy for Research Involving Ionising & Non Ionising Radiation.pdf	25/05/2025	Executive Medical Director	Currently undergoing updates and will hopefully be ready for the Senior Managers meeting in January, and following approval will be submitted to SCEG.
ES01 - BCUHB Asbestos Policy & Management Plan.pdf	31/05/2025	Director of Environment and Estates	No update received.
PC 01 - BCUHB Patient Access to Planned Care Policy - Cymraeg.pdf	30/07/2025	Chief Operating Officer	No update received.
CRF01 - North Wales Clinical Research Facility (NWCRF) - Operational Framework Policy.pdf	15/08/2025	Executive Medical Director	Under review between wider R&D.
RD01 - Research Governance Policy.pdf	17/08/2025	Executive Medical Director	The other are currently undergoing updates and will hopefully be ready for the Senior Managers meeting in January, and following approval will be submitted to SCEG.
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	31/08/2025	Executive Medical Director	Currently being worked on 12/25.
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	01/09/2025	Executive Medical Director	Not due till Jan 2026. Policy Team Comments - According to our records this is over due so we will need a more in depth reason regarding the change in review date according to the Medical Directors Office.
PTR01 – Integrated Concerns Policy .pdf	01/09/2025	Executive Director of Nursing	The policy has been reviewed and planned to go to both QSG and then up to execs policy group approval.
NU33 - All Wales Thromboprophylaxis Policy.pdf	01/11/2025	Chief Operating Officer	No update received.
INF06 - Policy for Clinical Coding.pdf	08/11/2025	Chief Digital Information Officer	No update received.
IPC05 - Outbreak Reporting & Control Policy, Including Major Outbreaks.pdf	20/12/2025	Executive Director of Nursing	No update received.

Audit Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	17 February 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
Members are asked to: • NOTE the summary of business considered in private session to be reported in public • NOTE the forward workplan • NOTE the paper on Learning from Events Report (LFER)

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 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 item was considered in private at the meeting held on
 - AC25.178 Local Counter Fraud Service Progress Report (Private)
 - AC25.179 Finance Update
 - AC25.180 Update on Llandudno Orthopaedic Hub
 - AC25.181 Breach to Standing Financial Instructions (SFIs)

4.2 **Committee Forward Work Plan**

- 4.2.1 The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

4.3 **Learning from Events Report (LFER)**

4.3.1 The attached report on Learning from Events provides an update on the Health Board's management of Learning from Events Reports (LFERs) required by the Welsh Risk Pool (WRP). At the current reporting point, there are 18 overdue LFERs, representing a modest deterioration compared with the end-November position, and concentrated within a small number of IHCs/Divisions.

4.3.2 Notwithstanding this short-term movement, the overall position reflects a substantial and sustained improvement. Overdue LFERs have reduced from 106 in September 2024, to 79 in January 2025, and to 18 by January 2026, demonstrating significant progress following targeted recovery actions.

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 matters considered in Private at the 4 December 2025 meeting.
- **NOTE** The Committee forward workplan.
- **NOTE** the progress on managing Learning from Events Report (LFER)

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 CRR-16 – Leadership/Special Measures

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:	Not necessary for this report
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:	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog 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?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment Have you considered the counter fraud impacts	Do/Yes: ☐	Naddo/No: ☒
	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.	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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.

Audit Committee – Non-Routine Committee Business Workplan

(1 April 2024 – date)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
29.07.25	Action AC25/32.1 from Audit Committee	Pam Wenger	Information Governance and Records Management	A session on records management to take place with the Executive Committee and come back to the Committee as a substantive item.	Dylan Roberts	Pam Wenger	16.12.25	Being discussed with the DDaT team how to take this forward
21.07.25	Action AC25/70.1 from Audit Committee 08.05.25	Pam Wenger	Clinical Audit Improvement Plan	Clinical Audit Plan to go to QSE in July and come back to Audit Committee to confirm progress.	Joanne Shillingford	Clara Day	16.12.25	CLOSED received
16.01.25	Audit Committee action AC25/05.4	Audit Committee	Final Internal Audit Report on Consultant Job Planning	Progress and oversight to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.	Sree Andole Nick Graham	Pam Wenger	16.12.25	CLOSED - received
08.01.25	Action AC24/151.1 from Audit Committee	Pam Wenger	Review of Centre for Mental Health and Society (CfMHaS) / Report on FOI Request Email from PM 01.07.25 still in the procurement stage so report not due to be ready until end of August	A full evaluation report to be presented at Audit Committee – this was due to go to Jan / March but put forward for April meeting as the review will be commissioned externally.	Phil Meakin	Pam Wenger	16.12.25	CLOSED received
04.03.25	Suggested as part of discussion at meeting 04.03.25	Pam Wenger	Standing Orders Reservation and Delegation of Powers	Full review of Standing Orders Reservation and Delegation of Powers	Philippa Peake-Jones	Pam Wenger	19.08.25	CLOSED Going to Comm in Aug 25
12.06.25	Email from PW / TA	Pam Wenger	Audit Wales Planned Care Report	Management response on the Planned Care report to be presented to the Committee.	Tehmeena Ajmal Russell Caldicott	Tehmeena Ajmal Russell Caldicott	19.08.25	CLOSED Going to Comm in Aug 25
17.06.25	Email from PW / RC	Pam Wenger	Historical Symphony Contract	Paper to be presented in private	Alison Bishop producing paper	Russell Caldicott	19.08.25	CLOSED Going to Comm in Aug 25
31.03.25	Email from Danielle Timmins 31.03.25	Danielle Timmins	Counter Fraud Annual Report	Counter Fraud Annual Report to go to Audit Committee in June 25.	Danielle Timmins	Russ Caldicott	24.06.25	CLOSED Went to Comm in June 25
16.01.25	Audit Committee item AC25/04	Audit Committee	The Role of Internal Audit	The video developed has been shared at the AC Development Session in Feb 25 and an update to be provided to the April meeting in relation to the Comms plan and revised video.	Glesni Driver Dave Harries	Pam Wenger	30.04.25	CLOSED Went to Comm in May 25
16.01.25	Action AC25/10.1 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies Report on overdue policies (not WCDs)	An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April.	Glesni Driver	Pam Wenger	30.04.25	CLOSED Went to Comm in May 25

25.02.25	Discussion with PW and PPJ re: March 25 agenda	PW & PPJ	Annual Report Compliance with the Corporate Governance Code	PPJ agreed with PW to put this forward from March 25	Philippa Peake-Jones	Pam Wenger	30.04.25	CLOSED Went to Comm in May 25

Audit Committee

LEARNING FROM EVENTS REPORTS (LFER)

Date of Meeting	17 February 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Matthew Joyes Deputy Director for Legal Services
Lead Executive Team Member name and title	Pam Wenger Director of Corporate Governance

Report Purpose	For Noting

Executive Summary

This report provides an update on the Health Board's management of Learning from Events Reports (LFERs) required by the Welsh Risk Pool (WRP). At the current reporting point, there are 18 overdue LFERs, representing a modest deterioration compared with the end-November position, and concentrated within a small number of IHCs/Divisions.

Notwithstanding this short-term movement, the overall position reflects a substantial and sustained improvement. Overdue LFERs have reduced from 106 in September 2024, to 79 in January 2025, and to 18 by January 2026, demonstrating significant progress following targeted recovery actions.

The majority of current overdues relate to LFERs that have been submitted but deferred by WRP pending further evidence, indicating that the principal challenge is now the quality and evidencing of learning rather than failure to submit reports.

Strengthened governance arrangements remain in place, including weekly oversight, director-level accountability and an earlier internal submission deadline. Financial exposure continues to be monitored, with year-to-date performance improved compared with the previous financial year. The Executive Committee is asked to note this report.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
Pam Wenger Director of Corporate Governance	05-02-2026	Review of the draft

Acronyms / Glossary of Terms

Learning from Events Report (LFER)	A mandatory report required by the Welsh Risk Pool for every settled liability claim and redress case. The LFER sets out the circumstances of the event, the learning identified, actions taken, and supporting evidence to demonstrate improvement and reduce the risk of recurrence.
Welsh Risk Pool (WRP)	The national NHS Wales risk-sharing and indemnity scheme, hosted by NHS Wales Shared Services Partnership. The WRP oversees claims management, reimbursement, learning requirements and assurance across Welsh Health Boards and Trusts.
Overdue LFER	An LFER that has not been submitted to the Welsh Risk Pool within the required timescales, including the Health Board's internal deadline and/or the WRP submission deadline.
Deferred LFER	A Learning from Events Report that has been reviewed by the Welsh Risk Pool but not accepted, with further evidence or clarification requested before reimbursement can be confirmed. Deferred LFERs remain subject to timescales and may attract penalties if not resolved.
WRP Penalty	A financial charge applied by the Welsh Risk Pool where an LFER is submitted late or remains outstanding beyond agreed timescales. Penalties are recharged internally to the relevant IHCs/Divisions.

1. SITUATION

- 1.1 The Health Board continues to maintain focused oversight of Learning from Events Reports (LFERs) required by the Welsh Risk Pool (WRP) as part of the clinical negligence, personal injury and redress reimbursement process. At the current reporting point, there has been a modest deterioration in the number of overdue LFERs compared with the position reported at the end of November, with the overdue position now standing at 18 cases, concentrated within a small number of IHCs/Divisions.
- 1.2 Despite this short-term deterioration, overall performance demonstrates sustained improvement when compared with the position reported in January 2025 at the start of recovery efforts, when a significantly higher volume of overdue LFERs was recorded. The Health Board continues to take targeted action to address delays, reduce the risk of further deferrals by WRP, and embed more sustainable

improvements in the quality and timeliness of submissions over the remainder of the year.

- 1.3 Financial exposure associated with LFER non-compliance remains under active review. While WRP penalties continue to be incurred in-year, the year-to-date position compares favourably with the previous financial year, reflecting improved overall performance despite ongoing operational pressures.

2 BACKGROUND

- 2.1 Learning from Events Reports (LFERs) are a mandatory national requirement of the Welsh Risk Pool and form a core part of the liability claims and redress reimbursement framework. For every settled liability claim and redress case, an LFER must be submitted, with supporting evidence, within defined timescales to demonstrate learning, improvement actions and assurance that the risk of recurrence has been mitigated. Reimbursement of claims is conditional upon acceptance of the LFER by WRP, and financial penalties may be applied where submissions are late or where LFERs are deferred due to insufficient evidence. The WRP can levy a penalty, traditionally set at £2,500 per late LFER, which may recur at subsequent bi-monthly WRP Committee meetings where cases remain unresolved.
- 2.2 The Health Board has historically experienced challenges with the timeliness and quality of LFER submissions. These issues were reported to the Executive Team and Audit Committee in January 2025 alongside a recovery plan and revised operating procedure. That paper highlighted a high volume of overdue LFERs and set out a programme of improvement, including enhanced oversight, simplification of processes, and clearer accountability within IHCs and Divisions.
- 2.3 Since that time, the Health Board has embedded weekly oversight reporting, strengthened senior sign-off arrangements, and implemented process changes designed to improve both timeliness and quality. These actions have delivered a substantial reduction in the overall overdue position over the past year, albeit with some volatility remaining as pressures fluctuate across services and as WRP scrutiny of learning quality has increased.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 Current performance and trajectory

The current overdue position remains significantly improved when compared with the position reported in early 2025. Overdue LFERs are concentrated within a small number of IHCs/Divisions rather than being systemic across the organisation, enabling targeted intervention and escalation where required.

At the end of September 2024, when the matter was initially escalated, the Health Board had 106 overdue LFERs. This reduced to 79 overdue LFERs by January 2025 at the start of targeted intervention, before reducing further to 18 overdue LFERs by January 2026. This represents a reduction of 60 LFERs (approximately 76%) between January 2025 and January 2026, and a reduction of 87 LFERs (approximately 82%) when compared with the end-September 2024 position,

demonstrating a substantial and sustained improvement in the overdue LFER trajectory over the year.

3.2 **Quality and deferrals**

A notable proportion of the outstanding workload relates to LFERs that have been deferred by WRP pending further evidence. These deferrals increasingly focus on the quality and robustness of learning, including evidence of dissemination, clinician reflection and support, training compliance, and the implementation and review of relevant pathways or policies. This reflects heightened national scrutiny and reinforces the need for early assurance and robust evidence prior to submission.

Of the 18 overdue LFERs, 13 cases (72%) relate to LFERs that have already been submitted to WRP but have been deferred pending further evidence, with the remaining 5 cases (28%) relating to LFERs that are overdue for initial submission. This profile indicates that the principal challenge at this stage is the evidencing of learning, rather than a failure to submit LFERs.

3.3 **Process improvements**

In response to feedback and operational learning, an earlier internal deadline has been introduced, set two weeks in advance of the WRP submission deadline. This change is intended to allow additional time for internal review, challenge and evidence-gathering, reducing the likelihood of late submissions and WRP deferrals. This adjustment complements existing Datix-based tracking, weekly reporting, and director-level oversight within IHCs and Divisions.

As a result of the improvements made to the oversight and management of LFERs, the Health Board has been asked to share its approach with a number of other Health Boards. This has included presenting the revised process and governance arrangements at the National Welsh Risk Pool Committee, supporting wider system learning and demonstrating alignment with emerging good practice across NHS Wales.

3.4 **Financial position**

WRP penalties continue to be incurred in-year and are recharged to the relevant IHCs/Divisions. However, the year-to-date penalty position remains substantially lower than the total incurred in the previous financial year, providing assurance that overall compliance and control have improved. Financial exposure continues to be actively monitored as part of routine governance and escalation arrangements.

In the previous financial year, the Health Board incurred 69 WRP penalties, each valued at £2,500, resulting in a total cost of £172,500. In the current financial year to date, 23 penalties have been applied at £2,500 each, with a total value of £57,500. While penalties continue to be incurred, the year-to-date position represents a significant improvement compared with the previous year and reflects strengthened oversight and management of LFERs, notwithstanding ongoing operational pressures within specific services.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 There are several risks:

- **Risk of further deterioration in overdue position:** Ongoing operational pressures within a small number of IHCs/Divisions may result in additional LFERs becoming overdue, particularly where capacity constraints or competing priorities persist and recovery actions have not yet been fully completed.
- **Reputational and assurance risk:** Failure to demonstrate sustained improvement in LFER compliance may undermine assurance to the Board, Committees and external stakeholders regarding organisational learning and risk management.
- **Financial risk:** Although year-on-year performance has improved, continued penalties represent an ongoing financial risk and reinforce the importance of maintaining focus on both timeliness and quality of submissions.

5 RECOMMENDATIONS

5.1 The Audit Committee is asked to note this report.

ASSESSMENT	
Link to Strategic Priorities	    
	1. Building an effective organisation
	If more than one applies, please list below: N/A
Design Principles	People First
	If more than one applies, please list below: N/A
Corporate Risks and Board Assurance Framework	N/A
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies, please list below: N/A

IMPACT ASSESSMENTS		
Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	The associated duties are not engaged in this case.
Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	The associated duties are not engaged in this case.
Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality All Apply	Domains of Quality All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
	N/A	N/A
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	N/A
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	The associated duties are not engaged in this case.
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	The associated duties are not engaged in this case.
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	The associated duties are not engaged in this case.
Legal	Yes (Include further detail below)	
	Claims in NHS Wales are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as well as standards set by the Welsh Risk Pool and UK wide requirements for litigation such as the Civil Procedure Rules.	
Reputational	Yes (Include further detail below)	
	Failure to demonstrate sustained improvement in LFER compliance may undermine confidence and reputation.	
Resource Impact (People / Financial)	Yes (Include further detail below)	
	The Health Board is indemnified by the Welsh Risk Pool for clinical negligence matters, with an excess of £25,000, although the contribution to the risk share is growing. The WRP apply penalties as detailed in the paper.	

Audit Committee

DIRECTORS' ACCOUNTABILITY STATEMENT 2026-27

Dyddiad y Cyfarfod Date of Meeting	17 February 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Pam Wenger, Director 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 Approval

Crynodeb Gweithredol Executive Summary

The purpose of this report is to present the **Draft Directors' Accountability Statement for 2026–27** to the Audit Committee for approval. The Statement forms a core component of the Health Board's strengthened governance framework, and responds directly to the organisational challenges highlighted through the *Foundations for the Future* Programme. **The Directors Statement is applicable to all Members of the Executive Team.**

This Programme identified longstanding issues relating to leadership clarity, accountability, inconsistency of practice, and weaknesses in internal control across Betsi Cadwaladr University Health Board (BCUHB). In parallel, statutory and regulatory requirements set by NHS Wales, particularly the NHS Wales Planning Framework and the Chief Executive's Statement of Internal Control require a more robust approach to assurance, risk management, and performance oversight.

The Director's Accountability Statement supports this by setting out clear expectations for governance, risk, quality, finance and regulatory compliance within each directorate. It also establishes an in-year escalation process, ensuring that any risks, performance concerns, governance issues or regulatory expectations that exceed Executive tolerance levels are escalated promptly to the Executive Committee or, where necessary, directly to the Chief Executive. This ensures transparency, improves organisational grip, and prevents year-end assurance gaps.

Engagement undertaken to date includes review by the Chair of the Audit Committee, Head of Internal Audit, Chief Executive and Executive Team Members, all of whom were supportive subject to minor amendments. There are **no matters for escalation** to the Board arising from this report.

The Audit Committee is asked to:

- **Note** the report; and
- **Support** the implementation of the Accountability Statement process from 2026 onward, noting that the Audit Committee will provide oversight as part of the Health Board's overall governance and accountability mechanisms.

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
Chair of Audit Committee	30/01/26	Support with minor amendments
Head of Internal Audit	07/01/26	Support with minor amendments
Chief Executive Officer	07/01/26	Support with minor amendments
Executive Team Members	30/01/26	Comments noted
Executive Director of People Services and Organisational Development	04/02/26	Support with minor amendments
Executive Committee	11/02/2026	Approved with minor amendments and agreement to ensure support and development on three lines of defence

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

DAAS	Directors' Annual Accountability Statement

DIRECTORS' ACCOUNTABILITY STATEMENT 2026-27

1. Y SEFYLLFA SITUATION

- 1.1 The purpose of this report is to provide the Audit Committee with the Draft Directors' Accountability Statement for 2026-27

2. Y CEFNDIR BACKGROUND

- 2.1 The *Foundations for the Future* Programme was commissioned to address long-standing structural, cultural and operational challenges within Betsi Cadwaladr University Health Board (BCUHB). It identified significant issues relating to **roles and responsibilities, accountability, leadership, bureaucracy, and inconsistency of practice across the organisation.**
- 2.2 Parallel to this, statutory and regulatory expectations for NHS Wales — including the NHS Wales Planning Framework and the Chief Executive's Statement of Internal Control require strengthened governance, improved risk management, and transparent, credible assurance.
- 2.3 The Health Board's governance-strengthening programme, and introduction of Directors' Annual Accountability Statement (DAAS) are central to responding to these challenges and expectations.
- 2.4 The Directors' Annual Accountability Statement (DAAS) will be considered alongside the Accountability Agreements which are issued to budget holders at the start of the financial year. These arrangements will need to be integrated in the Performance Management Framework.

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

- 3.1 This paper highlights key matters requiring the Board's attention and oversight, reflecting issues that exceed Executive tolerance levels and require Board-level scrutiny, decision-making or assurance. The escalations presented relate to areas where risks, performance concerns, governance issues, or external regulatory expectations have reached a point that necessitates Board involvement.

The matters for escalation include:

- **Significant risks** that have moved beyond Executive control, and now require Board oversight to ensure appropriate strategic mitigation

- **Performance, quality or safety concerns**, where the level of variation, pace of recovery, or underlying causes indicate the need for Board challenge or direction
- **Governance and accountability issues**, where gaps in assurance, internal control weaknesses, or systemic behaviours align with themes identified through the *Foundations for the Future* Programme, requiring Board visibility to support organisational improvement
- **Regulatory or audit recommendations** that carry strategic implications, or where progress has stalled and requires Board intervention to unblock or reprioritise
- **Strategic decisions or resource dependencies** that sit beyond Executive delegation and require formal Board approval or endorsement

4. **SUMMARY OF ACCOUNTABILITY STATEMENT AND IN-YEAR ESCALATION PROCESS**

- At the end of each financial year, every Executive Team Member will be required to produce a Directors' Annual Accountability Statement for submission to the Chief Executive. This forms a core part of the Health Board's overarching system of internal control, ensuring each Director provides clear, evidence-based assurance on governance, risk management, performance, quality, financial stewardship, and compliance within their remit. The Head of Internal Audit will independently review all statements to confirm alignment with audit findings and to support the Chief Executive's preparation of the Statement of Internal Control, as required under NHS Wales governance expectations.
- In addition to this annual process, Directors are required to escalate significant issues during the year through established Executive routes. Where risks exceed delegated authority, where there are serious performance, quality or safety concerns, or where governance or control weaknesses emerge, Directors must escalate promptly to the Executive Committee and, where necessary, directly to the Chief Executive. This aligns with the findings of the *Foundations for the Future* Programme, which highlighted the need for clearer accountability, more consistent governance practice, and improved organisational grip.
- This combined approach ensures there are **no year-end surprises**, strengthens organisational governance, and provides the Board and Chief Executive with continuous, reliable, and triangulated assurance throughout the year.

5. **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS BOARD ASSURANCE FRAMEWORK / MATTERS FOR ESCALATION**

There are no risks or matters for escalation.

6. ARGYMHELLION RECOMMENDATIONS

6.1 Members are asked to:

- **NOTE** the report; and
- **SUPPORT** the process with effect 2026 noting the Audit Committee will consider as part of the overall governance and accountability mechanisms

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 CRR-16 – Leadership/Special Measures

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:	Not required for this report

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:	Not required 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 Leadership	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluedd Arfog:</i> Armed Forces Covenant Due Regard Duty	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required 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 required 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 required for this report
Cyfreithiol Legal	Yes (Include further detail below)	
	There are legal implications within the High Value Claims items reported	
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>	There is no direct impact on resources as a result of the activity outlined in this report.	
Resource Impact <i>(People / Financial)</i>		



DIRECTORS' ANNUAL ACCOUNTABILITY STATEMENT 2026/27

EXECUTIVE TEAM MEMBER NAME:	
DIRECTOR TITLE:	

1. INTRODUCTION AND PURPOSE

I confirm that I am personally accountable to the Board and the Chief Executive for the effective discharge of my statutory, regulatory, and delegated responsibilities within **Betsi Cadwaladr University Health Board**. This statement provides a formal annual account of how I have fulfilled those responsibilities during 2026/27 and supports the Chief Executive's Statement of Internal Control.

I understand my accountability for the quality of care provided to the people of North Wales, and will ensure that appropriate structures, controls and oversight are in place to maintain and improve standards.

In providing this statement, I confirm that I have exercised appropriate leadership, judgement, and oversight within my remit, and that I have sought and relied upon proportionate and credible assurance to satisfy myself that governance, performance, risk management, and internal control arrangements have operated effectively. Where weaknesses have been identified, I have taken action to address them and to ensure learning and improvement.

In discharging my role, I have acted in accordance with the Health Board's Values of **Compassion, Openness and Respect**, and the **Nolan Principles of Public Life**, ensuring that ethical conduct, transparency, and accountability underpin decision-making at all levels. I recognise my responsibility to promote both physical and psychological safety for staff, to foster an open and learning culture, and to ensure that concerns are raised, heard, and addressed appropriately.

2. GOVERNANCE FRAMEWORK

Within the areas for which I am responsible, I confirm that governance arrangements have operated in accordance with the Health Board's Governance Framework, including Standing Orders, Standing Financial Instructions, Scheme of Delegation, and Welsh Government accountability requirements. I have ensured that decisions taken within my remit were supported by appropriate information, subject to due scrutiny, and properly recorded.



I confirm that governance processes have upheld the Nolan Principles of Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership, and that I have acted promptly where governance arrangements required strengthening or where compliance fell below expected standards.

I have ensured clarity of roles and responsibilities, appropriate use of delegated authority, and effective escalation to the Executive Committee, Board Committees or the Board where matters exceeding tolerance require collective oversight or when public interest or concern would be such that the Executive Committee or Board would wish to be aware.

I also confirm that I operate within an established framework without necessarily escalating matters of concern to the Executive Committee, Chief Executive or Board, highlighting the importance of fostering a culture where concerns are routinely surfaced, not simply managed within operational boundaries.

3. **LEADERSHIP**

I confirm that I am accountable for shaping and sustaining a culture that supports openness, learning and high standards of behaviour across the organisation. I take responsibility for ensuring that our cultural expectations are clearly communicated, consistently modelled and reinforced through our governance and leadership practices.

I confirm that I am accountable for providing effective leadership and ensuring that robust governance arrangements are in place to oversee the quality, safety and performance of our services. I take responsibility for ensuring that decisions are transparent, evidence-based and aligned with our statutory duties.

I confirm that I create an environment where safety is prioritised, learning is encouraged and concerns are raised without fear. This is about shaping culture, not just managing processes.

I am responsible for modelling expected behaviours, supporting staff wellbeing, and ensuring that the workforce is treated fairly and with respect.

4. **COMPLIANCE, ASSURANCE, AND REGULATORY REQUIREMENTS**

I confirm that I ensure compliance with applicable statutory, regulatory, and policy requirements within my remit. I have maintained oversight of internal and external audit findings, regulatory reviews, and other sources of independent assurance, and I have taken action to address any identified weaknesses.



I confirm that assurance has been drawn from a range of sources, including management controls, performance reporting, audit activity, and regulatory engagement, and that I have not relied on unverified or incomplete information when providing assurance to the Board.

[DIRECTOR COMMENT AND/OR EVIDENCE: including any areas of non-compliance or qualified assurance]

5. **OPERATIONAL PERFORMANCE, ISSUE MANAGEMENT AND SERVICE SUSTAINABILITY**

I confirm that I am accountable for the operational performance, safety, and sustainability of the services within my remit. I confirm that I have maintained oversight of operational performance throughout 2026/27, ensuring that emerging issues were identified early, understood, and addressed through appropriate management and escalation routes.

I have exercised active grip over operational pressures, including workforce, capacity, quality, and financial constraints, and have ensured that short-term mitigations did not compromise long-term service sustainability or patient safety. Where services have operated under sustained pressure, I have ensured that risks were explicitly recognised, recorded, and managed within the Health Board's risk management framework.

I confirm that operational issues were escalated appropriately, decisions were taken at the right level, and that I sought assurance that actions taken were effective.

[DIRECTOR COMMENT AND/OR EVIDENCE: including examples of operational recovery, issue resolution, or sustained pressures]

6. **QUALITY AND SAFETY**

I confirm that I have maintained oversight of quality and safety within my areas of responsibility and have ensured that systems for incident management, complaints handling, and learning from harm operated effectively. I have sought assurance that incidents, including serious incidents and never events where applicable, were identified promptly, investigated proportionately, and that learning was implemented to prevent recurrence.

I confirm that complaints were managed in a timely, fair, and compassionate manner, with a focus on responsiveness, openness, and learning. Themes and trends arising from incidents and complaints have been reviewed and used to inform service improvement and risk reduction.



Where quality or safety concerns were identified, I ensured that appropriate action was taken, risks were escalated where required, and that I received assurance on the effectiveness of remedial actions.

[DIRECTOR COMMENT AND/OR EVIDENCE: including improvements, learning implemented, or known challenges]

7. PERFORMANCE MANAGEMENT AND ISSUE GRIP

I confirm that performance management arrangements within my remit have operated effectively and have supported timely identification and resolution of issues. Performance information has been reviewed regularly, challenged appropriately, and used to inform decision-making and prioritisation.

I have ensured that underperformance was addressed through clear accountability, support, and corrective action, and that persistent or systemic issues were escalated through appropriate governance routes.

[DIRECTOR COMMENT AND/OR EVIDENCE: including examples of intervention, recovery, or sustained improvement]

8. PLANNING, TRANSFORMATION AND DELIVERY ACCOUNTABILITY

I confirm that I am accountable for the delivery of agreed plans within my remit, including commitments set out in the Annual Delivery Plan (ADP) and Integrated Medium-Term Plan (IMTP). I have ensured that plans were realistic, aligned to available resources, and underpinned by credible delivery trajectories.

I have maintained oversight of progress against agreed milestones, taken action where delivery has been at risk, and escalated concerns where commitments could not be met. I confirm that I have not relied on aspirational planning without delivery assurance and that risks to plan delivery were explicitly recognised and managed.

I have ensured that transformation and change activity supported the overall safety, quality, and sustainability of services, and that benefits were monitored and realised.

[DIRECTOR COMMENT AND/OR EVIDENCE: including delivery achievements, slippage, and learning]

9. RISK MANAGEMENT FRAMEWORK

I confirm that I hold ultimate responsibility for the identification, ownership, and management of risks within my Divisions/Directorates/Services. I have operated within the Board-approved risk appetite and ensured that risk considerations are embedded within operational and strategic decision-making.



I confirm that clear ownership of risks has been established at clinical, operational, and managerial levels, with defined accountability for mitigation and monitoring. Through the Board Assurance Framework, Corporate Risk Register, and Operational Risk Registers, I have assured myself that risks are accurately described, controls are effective, actions are tracked, and escalation occurs promptly where risks exceed tolerance.

I have actively sought assurance on the effectiveness of mitigation plans and have supported staff by providing clarity on decision-making, gaps in controls, and acceptable risk.

[DIRECTOR COMMENT AND/OR EVIDENCE: including examples of risks reduced, accepted, or escalated]

10. PROCUREMENT AND FINANCIAL STEWARDSHIP

I confirm that procurement activity within my remit has been conducted in compliance with Standing Financial Instructions, Welsh Government procurement policy, and relevant legislation. Tendering and contracting processes adhered to principles of fairness, transparency, and value for money, and were subject to appropriate approval and scrutiny.

I confirm that:

- All tendering and contracting processes adhered to principles of fairness, transparency, and value for money, consistent with the Nolan Principles and Health Board Values
- Procurement decisions were subject to appropriate scrutiny and approval through established governance channels
- To the best of my knowledge, no material breaches of procurement policy were identified during the year, and any minor compliance issues were promptly addressed
- Internal audit reviews of procurement controls provided assurance of compliance and highlighted areas for continuous improvement, which have been actioned.

[DIRECTOR COMMENT AND/OR EVIDENCE]

11. PARTNERSHIP AND COLLABORATION

I confirm that, where possible, I work collaboratively across health boards, local authorities and regional partnerships to improve population health and service integration.



12. DELIVERY OF AGREED RECOMMENDATIONS AND ACTION PLANS

Under my leadership, internal audit recommendations/findings have been implemented within agreed timescales and monitored through formal tracking arrangements.

I confirm that a structured follow-up process is in place to ensure sustained compliance and to prevent recurrence of identified issues.

[DIRECTOR COMMENT AND/OR EVIDENCE]

13. PERFORMANCE AGAINST OBJECTIVES

During 2026/27, I was accountable for delivering the following objectives:

[INSERT OBJECTIVES]

I confirm that these objectives have been delivered as agreed, or that variances have been identified, explained, and addressed through appropriate corrective action.

[INSERT COMMENT AND/OR EVIDENCE]

14. SIGNIFICANT ISSUES AND REMEDIAL ACTIONS

No material weaknesses in internal control were identified during the year.*

OR

One or more material or moderate weaknesses in internal control were identified. The nature of the issue(s), actions taken, and planned further actions are set out below:*

Issue:

- Description of the issue during the year
- Actions taken and improvements achieved
- Further actions planned for the year ahead.



15. **FUTURE PRIORITIES**

Looking ahead, I will continue to lead improvements within my remit, focusing on:

[INSERT PRIORITY AREAS]

ensuring continued alignment with organisational priorities, Welsh Government expectations, the Health Board's Values, and the Nolan Principles. I will proactively address emerging risks, strengthen assurance, and support a culture of openness, learning, and accountability.

DIRECTOR:	
TITLE:	
DATE:	

Audit Committee

ANNUAL REPORT 2025/26

Dyddiad y Cyfarfod Date of Meeting	17 February 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 Approval

Crynodeb Gweithredol **Executive Summary**

The purpose of this report is to provide Audit Committee with the arrangements for the production of the 2025/26 Annual Report and Accounts.

The Corporate Governance and Finance Directorates will be working with Health Board, Audit Wales and Internal Audit colleagues to achieve early and clear arrangements in place for the production of the Annual Report and its constituent parts.

This report is seeking to give Assurance to the Audit Committee that robust arrangements are in place including:

- Timescales for the development of the Annual Report and Accounts
- Clear roles and responsibilities for the production of the Annual Report and Accounts
- Proposed dates of future Audit Committee and Board meetings where the Annual Reports and Accounts are to be considered.

This outline timetable has been shared with Audit Wales colleagues and Internal Audit colleagues.

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

Those involved in production of the Annual Report	26/01/26	Reviewing and agreeing the timeline for the Annual Report

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

ANNUAL REPORT 2025/26

1. Y SEFYLLFA SITUATION

- 1.1 Health boards in Wales produce an Annual Report because it is a statutory public-accountability requirement that explains what the organisation does, how it has performed, how it has managed public money, and whether it has met its legal duties. The report sets out in a transparent, accessible way how the Board has planned, delivered, and improved healthcare services for its population over the year, including performance against Welsh Government targets, governance and risk management arrangements, and financial stewardship as required under legislation such as the NHS Finance (Wales) Act 2014 and the prescribed Accountability Report format. It provides assurance to citizens, Welsh Government, Audit Wales and other stakeholders that the Health Board is operating effectively, using resources appropriately, and meeting its obligations for openness, governance, and public reporting

2 Y CEFNIDIR BACKGROUND

- 2.1 The timeline builds on last year's approach working closely with Internal Audit and Audit Wales. Further discussions with Audit Wales will determine if weekly programme meetings are required.

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

- 3.1 The plan has been developed with members of the Health Board and will be shared with Audit Wales and Internal Audit colleagues. The plan reflects the inter-dependencies of key information from Welsh Government, including the Manual for Accounts which is the key technical document that sets the content requirement for the Reports. The draft Manual for Accounts has now been received and is currently being considered by the Health Board's finance team for has returned any comments to Welsh Government.
- 3.2 Last year the Audit Committee received a self-assessment of compliance with the Corporate Governance Code and this will be reported to the Audit Committee on 21 April 2026.
- 3.3 The timeline is as follows:

08/04/26	Draft Annual Governance Statement for comments	Executive Committee
21/04/26	Draft Annual Governance Statement for comments (Private)	Audit Committee
01/05/26	Submit Draft Accounts to HSCEY Finance and Audit Wales	Welsh Government cc to Audit Wales
08/05/26	Submit Accountability Report and Remuneration Report	Welsh Government cc to Audit Wales
19/05/26	Draft Annual Report and Accounts	Audit Committee
17/06/26	Annual Report and Accounts	Executive Committee
23/06/26	Annual Report and Accounts	Audit Committee
25/06/26	Annual Report and Accounts	Board
29/07/26	Annual Report and Accounts	AGM

- 3.4 The Annual Quality Report is planned to be aligned to the timescales for reporting to the June Board; the Quality Team are progressing the arrangements.

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

There are no risks or matters for escalation.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

5 ARGYMHELLION RECOMMENDATIONS

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

- **CONSIDER** the arrangements that have been developed for the production of the Annual Report for 2025/26.
- **RECEIVE** assurance on the arrangements for the production of the Annual Report for 2025/26.



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	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		
Public Sector Equality Duty: Compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Human Rights Act <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to the Welsh Language requirements?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to giving 'due regard' to the principles of the Armed Forces Covenant <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Socio-economic disadvantage <i>Have you exercising your duties in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
<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 Choose an item.	Meysydd Ansawdd Domains of Quality Effective
	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny:	Not required



	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: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
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:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not 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.	

Audit Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod Date of Meeting	17 February 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Nesta Collingridge, 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	For Discussion

Crynodeb Gweithredol **Executive Summary**

This report presents the **January 2026 Corporate Risk Register** for Audit Committee review. All 11 strategic risks have been updated by Executive Leads and scrutinised through the Risk Scrutiny Group (RSG).

Ten of the eleven risks remain above the Health Board's risk appetite, demonstrating sustained strategic exposure across several operational and regulatory domains. Only **CRR2505 – Strategic Change** is currently within tolerance.

Across the Register, **91 actions** are in place:

- **18 completed**
- **71 progressing**
- **2 delayed**, both within *CRR2503: Population Needs*, primarily due to external dependencies and timing constraints already reported to PPHP Committee.

A concentration of actions fall due by **March 2026**, requiring Executive assurance that delivery timelines are realistic.

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
Head of Risk Management	16/01/2026	The Head of Risk Management conducted an assessment on all corporate risks, this has been presented to RSG and the risk leads. It was suggested action plans should be outcome focused and measurable (including metrics where possible).

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework
PPHP	Planning, Population Health and Partnerships Committee

Corporate Risk Register January 2026

1. Y SEFYLLFA SITUATION

The purpose of this report is to escalate to the Audit Committee the identified gaps in assurance around the management of corporate risks, and to secure Executive action to strengthen controls. The report also provides assurance that all strategic risks have been reviewed by Executive Leads and the Risk Scrutiny Group as part of the January 2026 update.

2. Y CEFNDIR BACKGROUND

The overall corporate risk position remains largely unchanged since the previous reporting cycle. The level of exposure highlights:

- Persistent challenges in critical operational areas including **patient access, workforce sustainability, estates safety, digital resilience and regulatory compliance**.
- Insufficient pace in risk reduction relative to risk appetite.
- Variable maturity in the design and monitoring of action plans across risk owners.

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

RISK REGISTER REVIEW AS AT END JANUARY 2026

The report highlights the changes that have been proposed to the Health Board Corporate Risk Register which are proposed to be considered by the Executive Committee. The Risk Register attached (*Appendix 2 supporting papers*) provides the full details of the risks and the actions to reduce the risks.

On review of the Risk Register only **1 risk has reduced in the last 12 months**, whilst it is recognised that there has been good progress on the process and system of risk management, the actual management of the risk still requires significant focus and this an area for improvement as agreed with the Audit Committee.

The Committee is advised that since the last reporting cycle, there have been no changes to the scoring of any corporate risks, with ten of the eleven risks continuing to sit above the Health Board's risk appetite. Two actions linked to CRR2503 Population Needs have now become delayed, with commencement moved into 2026/27, and several actions scheduled for completion in March 2026 will require ongoing monitoring to confirm that the deadlines remain appropriate. A series of deep dives have been completed since the previous update, covering Safe Environment and Health & Safety in November 2025,

Timely Patient Access in December 2025, and Regulatory and Legislative Non-compliance in January 2026, with further deep dives scheduled for February 2026 for Future Demand & Sustainable Workforce and Leadership and Operating Model. -03 Population Needs have now become delayed, with commencement moved into 2026/27, and several actions scheduled for completion in March 2026 will require ongoing monitoring to confirm that the deadlines remain appropriate. A series of deep dives have been completed since the previous update, covering Safe Environment and Health & Safety in November 2025, Timely Patient Access in December 2025, and Regulatory and Legislative Non-Compliance in January 2026, with further deep dives scheduled for February 2026 for Future Demand & Sustainable Workforce and Leadership and Operating Model.

In addition, BAF2401 has now been formally closed, with all remaining actions transferred into CRR2508, and two private risks have been removed from the public register for consideration in private session. Overall, the corporate risk portfolio now consists of 91 actions (18 completed, 71 progressing, 2 delayed), alongside new direction from the Head of Risk Management to ensure that action plans are more outcome focused and measurable-01 has now been formally closed, with all remaining actions transferred into CRR25-08, and two private risks have been removed from the public register for consideration in private session. Overall, the corporate risk portfolio now consists of 91 actions (18 completed, 71 progressing, 2 delayed), alongside new direction from the Head of Risk Management to ensure that action plans are more outcome-focused and measurable

Overdue/Delayed Actions

Two actions are delayed relating to risk CRR25-03 'Population Needs' with both actions due to commence during 2026/27 with external dependencies.

Additional Action Required

The Committee should focus its scrutiny on the ten corporate risks that remain above the Health Board's stated risk appetite, ensuring that Executive Leads are providing sufficient assurance on the effectiveness of controls and the pace of mitigation.

As agreed, deeper consideration on the risks will be allocated to the Informal Executive meetings.

Risks	Lead	Risk Score
Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20
Future Demand & Sustainable Workforce	Executive Director of Workforce	16

Risks	Lead	Risk Score
Leadership and Operating Model	Executive Director of Workforce	16
Population Needs	Executive Director of Public Health	16
Modernising Infrastructure	Chief Digital Information Officer	20
Cyber & ICT Failure	Chief Digital Information Officer	20
Value Delivery and Financial Sustainability	Executive Director of Finance	20
Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	16
Safe Environment	Director of Environment and Estates	20
Health and Safety	Director of Environment and Estates	16

Risks above Health Board 25/26 appetite

Of the total 11 Corporate Risks, **ten** corporate risks above tolerance are for the oversight of the Committees and Board. One risk sits within the risk tolerance range within the appetite CRR25-05 'Strategic Change - Impacting Care and Staff Delivery'.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20	Quality <15
CRR25-02	Future Demand & Sustainable Workforce	Executive Director of Workforce	16	Quality <15
CRR25-03	Population Needs	Executive Director of Public Health	16	Quality <15

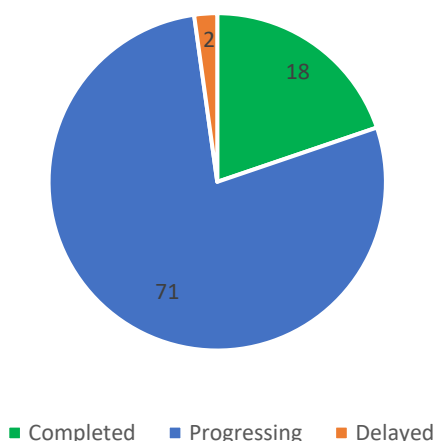
Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-04	Modernising Infrastructure	Chief Digital Information Officer	20	Quality <15
CRR25-06	Value Delivery and Financial Sustainability	Executive Director of Finance	20	Financial <15
CRR25-07	Leadership and Operating Model	Executive Director of Workforce	16	Quality <15
CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	16	Regulatory <15
CRR25-09	Safe Environment	Director of Environment and Estates	20	Regulatory <15
CRR25-10	Health and Safety	Director of Environment and Estates	16	Regulatory <15
CRR25-11	Cyber & ICT Failure	Chief Digital Information Officer	20	Quality <15

Action Plan status of Corporate Risks

Of the 11 Corporate Risks, 91 actions have been developed to mitigate the risks 18 actions have been completed, 71 actions are progressing and on track, with 2 delayed actions.



Action Plan Status



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

All risks have been reviewed and updated by the relevant services and approved by Executives.

The following risks were subject to a deep dive at the Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

November 2025

- CRR25-09 'Safe Environment'
- CRR25-10 'Health & Safety'

December 2025

- CRR25-01 'Timely Patient Access to Safe and Effective Care'

January 2026

- CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'

5. ARGYMHELLION RECOMMENDATIONS

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

-
- **Endorse** the Corporate Risk Register (January 2026) as the current consolidated position.
 - **Acknowledge** that ten risks remain above appetite and Executive Leads to confirm the actions requires to reduce the risk;
 - **Note** the incorporation of **BAF24-01** actions within **CRR25-08** and confirm that monitoring arrangements are sufficient.
 - **Advise** on further actions needed to strengthen internal controls, tighten accountability, and address identified assurance gaps.

6. CAMAU NESAF NEXT STEPS

1. Risk Scrutiny Group deep dive and considering feedback from the group and Head of Risk Management.
2. Approved Corporate Risks to be monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee
3. Submission of Corporate Risks to Board.

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	The Corporate Risk Register has been consolidated into 11 strategic corporate risks, aligned to the Health Board's strategic objectives and mapped to the Board Assurance Framework to strengthen oversight and clarity of assurance routes. Of these, ten risks remain above the Health Board's stated risk appetite, indicating continued areas of significant exposure that require enhanced monitoring and scrutiny. Only CRR25-05 Strategic Change – Impacting Care and Staff Delivery currently sits within tolerance.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

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</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

<i>requirements of the Welsh Language Standards)</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: ☐ Canlyniad/Outcome:	Naddo/No: ☒
	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>	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒

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

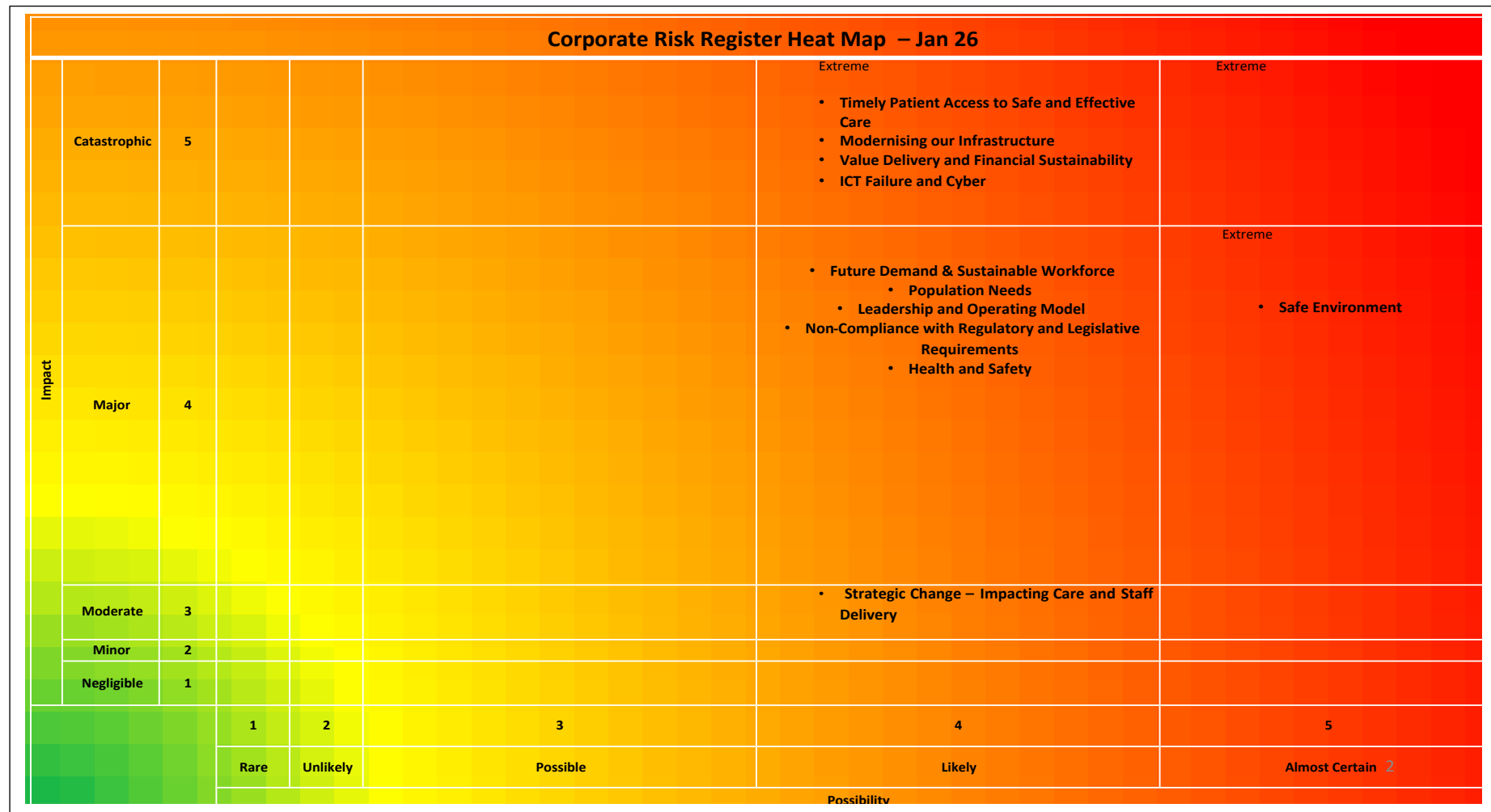
Appendix 1 – Corporate Risk Register Dashboard – January 2026

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4	12	Quality (<15)	Quality, Safety and Experience Committee	11	4	0	Four actions now completed Action plan to be reviewed
			20		Above Tolerance					
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4	8	Quality (<15)	People & Culture Committee	7	0	0	Action plans to be reviewed to include metric based for tracking outcome and impacts
			16		Above Tolerance					
EDoPH	CRR25-03	Population Needs	4x4	12	Quality (<15)	Planning, Population Health & Partnership Committee	13	0	2	13 actions with 11 progressing, 2 delayed actions due to external dependencies, to commence 26/27. Dental and community actions to be reviewed for impact and outcome.
			16		Above Tolerance					
CDIO	CRR25-04	Modernising our Infrastructure	5x4	12	Quality (<15)	Planning, Population Health & Partnership Committee	9	1	0	*Removed from report, private
			20		Above Tolerance					
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3	8	Quality (<15)	Planning, Population Health & Partnership Committee	6	2	0	Additional actions to be identified to reduce the risk to achieve the target risk score
			12		In Tolerance					
EDoF	CRR25-06			12	Financial (<15)	Performance, Finance and	4	2	0	

		Value Delivery and Financial Sustainability	5x4 20		Above Tolerance	Information Governance Committee				
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15)	People & Culture Committee	5	0	0	Action plans to be reviewed to include metric based SMART actions
					Above Tolerance					
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15)	Quality, Safety and Experience Committee	14	4	0	Following the closure of BAF risk BAF24-01, the remaining 4 open actions transferred onto this risk for continued monitoring.
					Above Tolerance					risk remains elevated due to fragmentation of compliance ownership and variable operational assurance
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15)	Performance, Finance and Information Governance Committee	9	0	0	Review of the risk undertaken by the service to align to operational aspects of the risk
					Above Tolerance					
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15)	Performance, Finance and Information Governance Committee	6	2	0	6 open actions, 2 actions completed with 4 open actions on track
					Above Tolerance					
CDIO	CRR25-11	Cyber	5x4 20	15	Quality	Planning, Population Health & Partnership Committee	9	4	0	*Removed from report, private.
					Above Tolerance					Target score remains high.



Appendix 2 – Corporate Risk Register Heatmap



Corporate Risk Register



Appendix 3 – Corporate Risk Register – January 2026

CRR 25-01	Risk Title: Timely Patient Access to Safe and Effective Care		Date Opened: 21/08/2025 (version 2 refined from 2023)
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 06/11/2025
Date Last Reviewed: 21/01/2025	Director Lead: Chief Operating Officer	Link to BAF: BAF24-07	Target Risk Date: 30/06/2027
There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome. This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts. This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.			
Mitigations/Controls in place		Additional Controls required	
1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels 2. 6 week rapid improvement plan with clinical and operational executive oversight 3. Quality, professional and operational standards 4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC		a. Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts. b. Fragility of social care provision causing delayed discharge and stranded patients c. Need for demand and capacity modelling and specialty-level trajectories d. Inadequate Neurodevelopment capacity to manage waiting list	



framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned. 5. Winter Resilience Plan complete evaluation and lessons learnt. 6. Revised Access policy to ensure standardised practice across the Health Board 7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice 8. Same Day Emergency Care (SDEC) services established at all acute sites 9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 11. Diagnostic Quality Management System accreditation system embedded 12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime		e. Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics. f. Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet g. Consistent application of "Our Next Patient Please" flow model. h. Health Board improvement goal for Colostrum Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.		
Actions		Action Owner	Due Date	Progression Analysis
b) Implement reset fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second winter Sprint 22 January – 4 February, supported by 3 diagnostics to target ongoing actions		Chief Operating Officer	08/12/2025	Complete

b) Complete demand and capacity analysis across Planned Care to inform forward activity planning As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery.	Programme Director, Planned Care	31/03/2026	Progressing
e) Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27	Associate Director, North Wales Managed Clinical Services	30/06/2026	Progressing (revised date from 20/10/2025)
b) Deliver December "Discharge Fortnight" - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability.	Chief Operating Officer	31/01/2026	Complete
Issue Quality Standards (Clinical Execs) and Operational Standards (COO) Define practice expectations to standardise risk, quality, and operational performance. Issued and integrated into daily actions	Chief Operating Officer	31/01/2026	Complete

g) Patient flow improvements: Implement “Our Next Patient Please” Move patients to wards ahead of predicted discharges; reduce ED congestion. Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways. SOP finalised	Chief Operating Officer	31/01/2026	Progressing
e Implementation of Health Board improvement goal for CDI (Colostrum Difficile Infection) reductions in 2025/2026	Deputy Director Of Nursing Infection Prevention and Decontamination	31/03/2026	Progressing
Planned care harms reviews on impact on patient safety and experience	Programme Director, Planned Care	TBC	Progressing
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development.	Chief Operating Officer	30/06/2026	Progressing
Winter plan developed with partners throughout Dec 2025	Chief Operating Officer	15/01/2026	Complete
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development	Chief Operating Officer	30/06/2026	Progressing



21/08/2025. 28/08/2025. 25/09/2025. 28/11/2025. 21/01/2026. — Inherent — Current — Target		Impact	Likelihood	Score
	Inherent Risk Rating	5	5	25
	Current Risk Rating	5	4	20
	Target Risk Score	4	3	12
	Risk Appetite	Quality <15		Not in Tolerance
	Position & Intended Outcome for Risk			
The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social				

	care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets. Intended Outcome: By 2027, patients consistently receive timely, effective, and safe care, evidenced by: • Reduction in long-wait patients (>104 weeks) and breaches of national access standards. • Fewer harm events linked to delayed care. • Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs). • Reduction in regulatory and legal cases associated with delayed access. • A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.



CRR 25-02	Risk Title: Future Demand & Sustainable Workforce		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: People & Culture Committee		Date Last Committee Review: 16/10/2025
Date Last Reviewed: 08/01/2026	Director Lead: Executive Director of People and Organisational Development	Link to BAF:	Target Risk Date: 31/03/2027
There is a risk that the organisation will not have a sustainable workforce to meet future patient demand. This may be caused by ongoing recruitment challenges (particularly in specialist roles), limited workforce planning to match future service needs, and increasing operational pressures across teams and departments. This may lead to staff burnout, reduced morale and retention, and an inability to consistently deliver safe, high-quality care placing additional strain on services and impacting patient outcomes.			
Mitigations/Controls in place			Additional Controls required



1. Strategic Recruitment Team supporting senior leadership, medical and dental consultant posts 2. Local IHC (Integrated Health Community) resourcing teams delivering recruitment activity against divisional priorities. 3. Recruiting Well / Joining Well programmes and recruitment campaigns. 4. Nurse Retention Lead and retention plan. 5. All-Wales Flexible Working policy implemented. 6. Speak Out Safely Multi-Disciplinary Team and Work in Confidence platform in place for staff concerns. 7. Workforce reviews underway in challenged specialties (ophthalmology, vascular, orthodontics, Neurodevelopment (ND), diagnostics).	a) Implement a system-wide Workforce Planning Framework that aligns health and social care workforce requirements with service demand and capacity modelling. b) Medical and Dental workforce engagement and management not fully effective. c) Fragile workforce pipelines in specialist services (ophthalmology, vascular, orthodontics, ND, diagnostics) (cross-theme). d) Retention measures not yet delivering consistent impact. e) Absence and sickness management requires stronger controls (linked to new Absence risk created Feb 2025).		
Actions	Action Owner	Due Date	Progression Analysis
Deliver “Recruiting Well, Joining Well, Leaving Well” programme across staff journey Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025 a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment This action will be reviewed as part of a deep dive in January 2026	Head Of Policy, Practice & Compliance, Workforce & Organisational Development	31/03/2026	Progressing

Targeted management of sickness absence, linked to new Absence risk	Head Of Policy, Practice & Compliance, Workforce & Organisational Development	31/03/2026	Progressing
The Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026			
Workforce modelling and specialty service plans for Ophthalmology, Vascular, ND and Orthodontics	Associate Director Workforce Optimisation, Workforce & Organisational Development	31/03/2026	Progressing
Workforce planning templates have been issued out to services and engagement is underway to support the completion. Vascular services are so far further along with this, having held an away day on 3 rd September. There are challenges in service leads having time/capacity to work on their workforce plans			
Develop Vascular workforce strategy and Phase 2 Business Case	Vascular Network Manager, Vascular Services	31/03/2026	Progressing
Recruitment and workforce model development for Orthodontics Academy model	Chief Operating Officer	Ongoing	Progressing
ND workforce business case approval via Executive Team. Business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	Fiona Wright, C&YP	31/03/2026	Progressing (revised date)



No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters			from 31/12/2025)																																																																				
Establish revised Radiology workforce model. Updated operational Diagnostic risk to be presented at divisional meeting to discuss on the 10/10/2025. This action is revised due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27	Associate Director, Diagnostics	30/06/2026	Progressing (revised date from 20/10/2025)																																																																				
<table><thead><tr><th>Date</th><th>Inherent</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>07/12/2023</td><td>20</td><td>16</td><td>8</td></tr><tr><td>13/12/2023</td><td>20</td><td>16</td><td>8</td></tr><tr><td>25/03/2024</td><td>20</td><td>16</td><td>8</td></tr><tr><td>21/05/2024</td><td>20</td><td>16</td><td>8</td></tr><tr><td>12/06/2024</td><td>20</td><td>16</td><td>8</td></tr><tr><td>29/10/2024</td><td>20</td><td>16</td><td>8</td></tr><tr><td>14/01/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>24/02/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>06/05/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>21/08/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>25/08/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>08/01/2026</td><td>20</td><td>16</td><td>8</td></tr></tbody></table> <table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Inherent Risk Rating</td><td>4</td><td>5</td><td>20</td></tr><tr><td>Current Risk Rating</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Target Risk Score</td><td>4</td><td>2</td><td>8</td></tr></tbody></table>				Date	Inherent	Current	Target	07/12/2023	20	16	8	13/12/2023	20	16	8	25/03/2024	20	16	8	21/05/2024	20	16	8	12/06/2024	20	16	8	29/10/2024	20	16	8	14/01/2025	20	16	8	24/02/2025	20	16	8	06/05/2025	20	16	8	21/08/2025	20	16	8	25/08/2025	20	16	8	08/01/2026	20	16	8		Impact	Likelihood	Score	Inherent Risk Rating	4	5	20	Current Risk Rating	4	4	16	Target Risk Score	4	2	8
Date	Inherent	Current	Target																																																																				
07/12/2023	20	16	8																																																																				
13/12/2023	20	16	8																																																																				
25/03/2024	20	16	8																																																																				
21/05/2024	20	16	8																																																																				
12/06/2024	20	16	8																																																																				
29/10/2024	20	16	8																																																																				
14/01/2025	20	16	8																																																																				
24/02/2025	20	16	8																																																																				
06/05/2025	20	16	8																																																																				
21/08/2025	20	16	8																																																																				
25/08/2025	20	16	8																																																																				
08/01/2026	20	16	8																																																																				
	Impact	Likelihood	Score																																																																				
Inherent Risk Rating	4	5	20																																																																				
Current Risk Rating	4	4	16																																																																				
Target Risk Score	4	2	8																																																																				

	Risk Appetite	Quality <15	Not in Tolerance
	Position & Intended Outcome for Risk KPIs to that inform our risk in this area as at Oct 2025; Overall Vacancy rate of 8.2%, slight improvement from 8.8% since the April 25. Clinical staff groups such as Registered Nursing, and Professional Scientific and Technical are seeing positive reductions in vacancy FTE (Full time equivalent) over the last year, however, increases in Clinical Services, Admin and Clerical, Estates and Ancillary and Medical and Dental are causing the vacancy rate to remain fairly static. Turnover stands at 7.7% and continues its downward trend from 10% in December 2022.		

	BCUHB continues to have the lowest reported sickness absence levels in Wales NHS, however, in August 2025 rolling sickness absence was 0.08% higher than during same period last year with Stress, anxiety and depression accounting for the largest proportion of absence.

CRR 25-03	Risk Title: Population Needs		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 06/11/2025
Date Last Reviewed: 24/12/2025	Director Lead: Executive Director of Public Health	Link to BAF: BAF24-06/07	Target Risk Date: 31/03/2028
There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population. This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services. This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.			

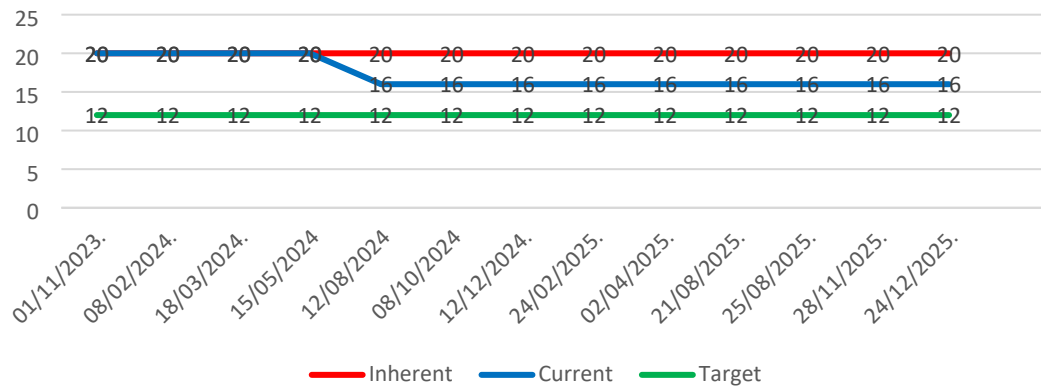
Mitigations/Controls in place		Additional Controls required		
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes “Case for Change” a structured, evidence-based mechanism to identify service gaps 3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways 4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases. 5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance. 6. CHC (Community Health Council) teams and community escalation frameworks in place 7. Welsh Government ND transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision. 9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery.		a. Limited system-wide prevention leadership and prevention not consistently prioritised b. Inconsistent commissioning approach across community and primary care services. c. The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB requires testing / simulation and socialising to ensure effectiveness d. Diabetes Programme support to establish cross cutting delivery plan e. Insufficient digital integration for community and Neurodevelopment services f. Fragility of Neurodevelopment workforce and reliance on temporary funding g. Lack of restorative dentistry service and workforce pipeline h. Evidence to support the Health Inclusion offer.		
Actions		Action Owner	Due Date	Progression Analysis
Complete Population Needs Assessment which informs the development and focus of Health Board Strategy. Data to support the Strategic Intent has been provided		Head Of Public Health Assurance &	31/03/2026	Progressing

	Development, Public Health		
Identify population health focused priorities for Health Board delivery Data to support the Strategic Intent has been provided alongside a number of evidence reviews. Programme plans within the Public Health Directorate include identification of need across a range of services, programmes and within the population.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Development of Population Health Management data and intelligence to ensure that Health Board is intelligence-led Delayed due to financial approval for spend against new posts. Recent agreement for posts to commence in 26/27.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans.	Head Of Public Health Assurance & Development, Public Health	31/03/2027	Progressing
Communicable disease outbreak management plan is embedded within services with an agreed schedule of simulation events and schedule of review by the Board The plan is available however it is recognised that the risk now lies within preparedness for communicable disease likelihood and severity. The associated risk descriptor has	Assistant Director Of Health	31/03/2026	Progressing

been updated to reflect this. The gaps around preparedness lie with communications, knowledge and application of existing plans and procedures.	Protection, Public Health		
Contribute to co-design Wellbeing, Prevention & Anchor Framework for North Wales as part of the Regional Partnership Board The Regional Partnership Board and BCUHB have develop a set of 7 key mission statements as the basis of the Framework.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy This work supports the development of the Health Board Health Inclusion Offer which will support access to health in key groups.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Establish Diabetes Change Programme providing programme management, milestones and delivery plan – in order to meet the Ministerial priorities (increasing the % receiving all 8 NICE Care processes)	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Delay

There is a risk to delivery of the Q3 and Q4 Diabetes objectives, related to system resources available. This is being mitigated through alignment with other Health Board key programmes of work to support efficient use of resources, but may result in changes to timelines for delivery. There are plans currently being implemented to progress the programme and these will extend into 26/27.			
Develop a Community and CHC Strategic Plan with Local Authorities.	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Management of CYP (Children and Young People) needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	CAMHS Programme Management Business	31/03/2026	Progressing (revised date from 31/12/2025)

No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters		Lead, Child & Adolescent Health		
Undertake a dental diagnostic deep dive to inform strategy In 2025 a review of the primary care dental service was undertaken to look at the current challenges in both General Dental Services (GDS) and the Community Dental Service (CDS). Key issues were identified in areas including leadership, performance, process, finance and people management. Progress within the service is now being monitored at a senior level via the IPEDG group, and a senior clinical review of the service is being planned for earlier 2026.		Assistant Director Of Primary Care	31/03/2026	Progressing
		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16



Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance
Position & Intended Outcome for Risk			
Life expectancy / healthy life expectancy is declining, and there are worsening health inequalities. This has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board's ability and capacity to deliver excellent healthcare services, meaning the Health Board's purpose must retain clear focus on prevention and early intervention to improve the health and wellbeing of the population			

CRR 25-05	Risk Title: Strategic Change – Impacting Care and Staff Delivery		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 06/11/2025
Date Last Reviewed: 31/12//2025	Director Lead: Executive Director of Transformation and Strategic Planning	Link to BAF: BAF24-02	Target Risk Date: 31/03/2026
There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes. This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services. This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, patient harm from long waiting times, delays, and backlog reviews, and increased frustration or disengagement among staff tasked with delivering change.			
Mitigations/Controls in place		Additional Controls required	



1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan 2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety, efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics). 3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk. 4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The Key Programmes reports into SP&SC Group, PPHP and Health Board.	a. Completion of the strategy development work, moving into the execution phase. b. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. c. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group. d. Organisational approach to change management to be developed and implemented.

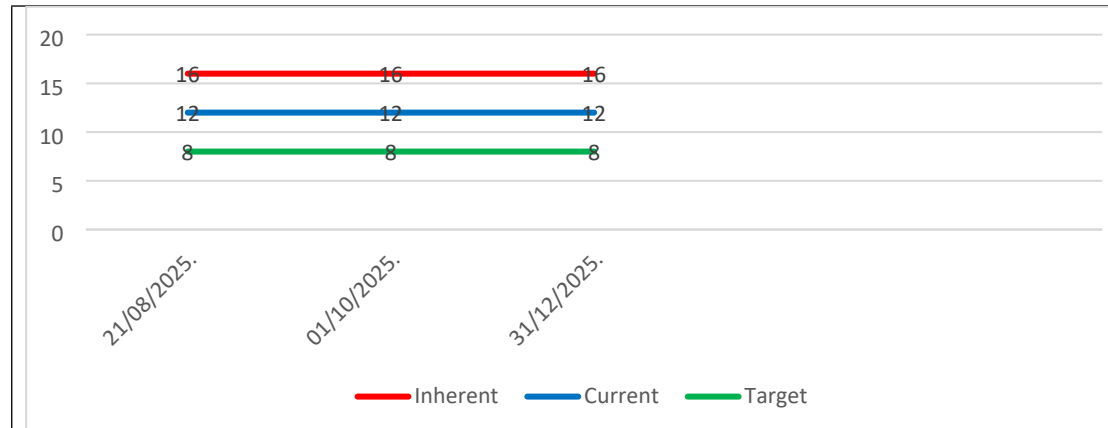


5. The Challenged Services report into SP&SC Group for review and oversight, Quality, Safety and Experience Committee (QSE) and Health Board.
6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings.
7. Terms of References for all groups with clear routes to escalation.
8. Legal and policy compliance including adherence to Welsh Government (WG) service change guidance.

Actions		Action Owner	Due Date	Progression Analysis
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval		Head Of Health Strategy And Planning, Transformation & Strategic Planning	31/01/2026	Progressing
Draft Strategic Intentions have been co-created, tested and refined with partners. The final draft strategic intentions will be presented to PPHP Committee on the 14th of January for review and comment and subject to any further amendments suggested by the Committee, the SIs will be submitted to the Board for approval on the 29th of January				

Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work Now referred to as the discovery phase. A range of engagement activity has taken place to date including sessions with the Board, sub committees and partners as well as specific Strategy Development events. Further work is required to gather the more quantitative pieces of evidence which are required to develop the output of this work - a case for change document and to develop the implementation plan	Head Of Health Strategy And Planning, Transformation & Strategic Planning	31/03/2026	Progressing
Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan Work has commenced and actions identified which will need to be developed into a work plan for the remainder of the financial year – actions include: - Establish initial Clinical Reference Group - Develop, test and finalise CSP methodology - Identify first tranche of CSP services - Raise awareness with staff, leveraging the opportunities presented by Foundations for the Future - Produce overarching case for change which will underpin the CSP Phase 2 work.	Head Of Health Strategy And Planning, Transformation & Strategic Planning	31/03/2026	Progressing
Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes.	Assistant Director of Transformation and Improvement	31/12/2025	Complete

Work is now complete and will continue to evolve as part of business as usual. Iterative changes have been made and the reporting has been very well received by Board Members for both Key Programmes and Challenged Services, with Board members stating that they feel more assured. Highlight reports in place for each programme/service in scope with summarised reporting through the Strategic Planning and Service Change Group and onwards to PPHP and Board.	(Interim), Transformation & Strategic Planning		
Mobilise the Challenged Services oversight group that will report into the SP&SC Group This is complete. The first meeting was held on the 28th November with the next meeting scheduled for the 26th January, with the group developing plans for the regionalisation of services and transitioning into broader Clinical Services Plan work.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete
Organisational approach to change developed as one of the enabling products within Foundations For The Future programme Work is progressing and on track. A core group is in place to drive forward the work with discovery work complete and commencement of design work. A paper outlining the approach has been socialised at the Strategy Workstream in December with further discussion scheduled as part of a deep dive during January.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/03/2026	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality <15		In Tolerance
Position & Intended Outcome for Risk			

CRR25-06	Risk Title: Value Delivery and Financial Sustainability		Date Opened: 21/08/2025 <i>(version 2 refined from 01/04/2024)</i>
	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 22/10/2025
Date Last Reviewed: 22/12/2025	Director Lead: Executive Director of Finance	Link to BAF: BAF24-03	Target Risk Date: 31/03/2026
There is a risk that the Health Board is unable to secure current non-recurrent (one off) allocations in future financial years, these allocations conditional on attainment of financial plans. If this resource is not secured then services will be required to deliver within a reduced envelop of funds and as a consequence patients may experience patient harm, reduced access to high-quality, timely and innovative care. The objective is to achieve long-term financial sustainability or maximise value from its spending. The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.			
Mitigations/Controls in place			Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive.			a. Prior year and current year financial performance material deterioration and therefore additional actions are required to

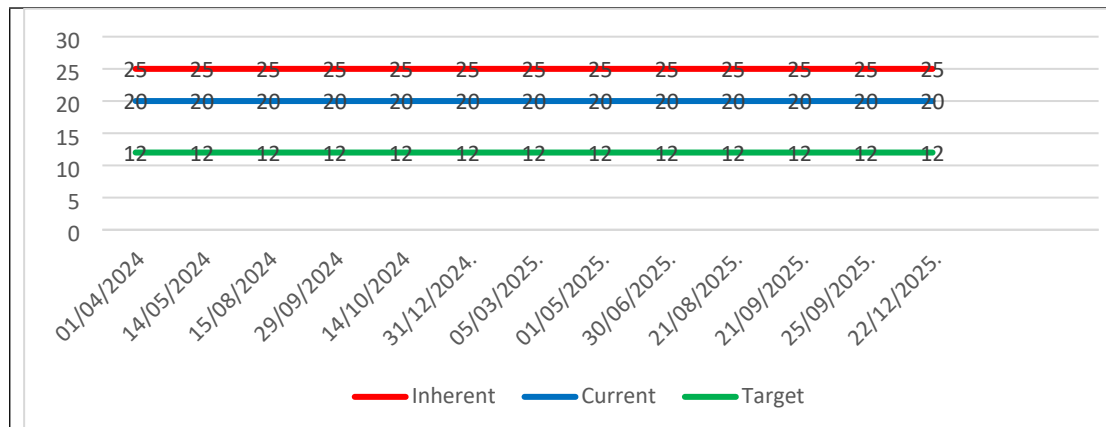


2. Value and Sustainability programme approach to 2025/26 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 3. Accountability Agreements to be issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8B and above where potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments. 5. Expansion of EEC (Enhanced Establishment Control) to be utilised for acting up and any increase in hours to be managed through the Enhanced Establishment Control process. 6. Cease use of agency in line with Ministerial Actions by end of September 2025 with the exceptionality of sign off by Executive Director of Nursing for all Agency nursing requests which are deemed clinically necessary beyond 31 October. This exceptionality for nursing requests is for all areas excluding Mental Health. Mental Health to be included from December 2025. 7. Non-Pay – all discretionary, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval 8. Internal scrutiny by central finance teams, of the Divisional financial assumptions, overspends and forecasts.	control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation through the Integrated Performance – Executive Delivery Group. b. Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with Performance, Finance and Information Governance Committee to mitigate against the year-to-date deficit and risk to attainment of target break even whilst assessing impact on patient safety and quality c. Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1.5% cost benefit and savings ask delivery is required as a minimum d. Gaps in delivery of savings targets mandated to be met on a recurrent basis e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement.



9. Financial reporting throughout the Health Board and to Welsh Government monthly via the Monthly Monitoring Return. 10. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements. 11. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and timely remediation of deficiencies through conformance reporting to Audit Committee and reporting through local finance reports to services 12. Review of SORD September 2025 to provide clarity with aim of authority moving towards earned autonomy 13. Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight	f. Prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26 completed for clinical schemes, with requirement to disinvest / identify alternative funding streams prior to new developments being funded. g. Consideration of additional strengthening of enhanced establishment controls and vacancy freeze for non-patient facing roles and continued reduction in variable staffing costs		
Actions	Action Owner	Due Date	Progression Analysis
B Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight	Director of Finance (DoF)	30/11/2025	Complete

C Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls.	Director of Finance	31/03/2026	Progressing	
B Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.	Chief Executive Officer (CEO) / Director of Finance	Monthly	Progressing	
Directorate teams to review medical devices capital replacement plans. The medical devices capital programme has been agreed for 2026-27 via the Medical Devices Capital Group. Refinements to the process will be made in line with progress with Foundations for the Future, which will determine the appropriate governance processes. Proposal to close the action	Assistant Director Of Ahps And Health Science, Therapies & Health Science	31/03/2026	Complete	
		Impact	Likelihood	Score
	Inherent Risk Rating	5	5	25



Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial/VfM <15		Not in Tolerance
Position & Intended Outcome for Risk			

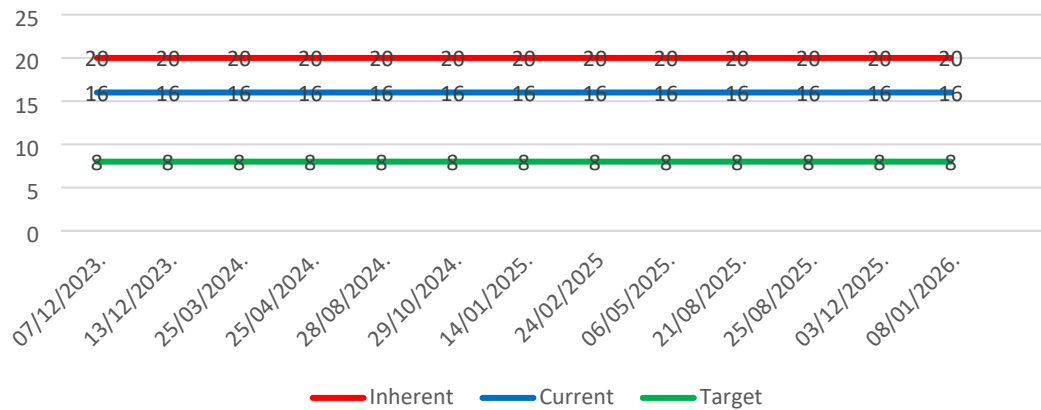
CRR25-07	Risk Title: Leadership and Operating Model	Date Opened: 21/08/2025 (version 2 refined from 2023)
	Assuring Committee: People & Culture Committee	Date Last Committee Review: 16/10/2025

Date Last Reviewed: 08/01/2026	Director Lead: Executive Director of People and Organisational Development	Link to BAF: BAF25-04	Target Risk Date: 31/03/2027
There is a risk that patients may experience delays, reduced quality of care, or fragmented services if the organisation does not have an operational model to deliver its strategic objectives This may be caused by fragile management structures, workforce shortages, leadership capabilities and competence and rising demand in high-need areas. This may lead to diminished organisational resilience, reduced capability to deliver foundations for the future, low staff morale, and risks to safe, high-quality care.			
Mitigations/Controls in place		Additional Controls required	
1. Strategic Recruitment team for senior leadership, medical and dental consultant posts 2. Local IHC resourcing teams driving recruitment priorities 3. Recruiting Well and Joining Well programmes 4. All-Wales Flexible Working policy implemented 5. Speak Out Safely MDT and Work in Confidence platform for staff to raise concerns 6. Organisational Culture Change Plan and Behaviours Framework approved by Board 7. Integrated Leadership Development Framework (ILDF) with measurement metrics 8. Increased nurse retention 9. Clear top-down commitment reinforced leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed)		a) Need for further embedding of workforce planning function b) Leadership development pathways not fully integrated c) Engagement and operational effectiveness with Medical and Dental workforce inconsistent d) Absence management requires stronger controls Compassionate leadership adoption requires measurable indicators across organisation e) Monitor any harm that arises to patient and service users due to the operating model changes.	



10. 60% senior staff trained in leadership through conferences and masterclasses				
Actions		Action Owner	Due Date	Progression Analysis
Implement Employee Engagement Plan with suite of indicators		Head of Employee Engagement and Experience - Corporate Office	31/03/2026	Progressing
The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026. • Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning • Refreshed reward and recognition activity to introduce monthly recognition awards 'Seren Betsi' with Executive involvement, improved annual staff achievement awards event (26.9.25) and currently reviewing approach to the celebration of long serving colleagues while holding ceremonies for those who have reached 25 years service in October 2025 • Involved local teams and introduced new local responsibility for actions in response to the 2024 NHS Wales Staff Survey to prepare the ground for the 2025 survey (goes live 6.10.25) • As of August 2025, two members of staff joined the team, bringing additional capacity to proceed with work to further develop and deliver employee engagement and experience-related improvements which will include				

mechanisms for both improving engagement and measuring engagement such as Pulse surveys			
Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched September 25. This will be used to inform the mid-level management ILDF leadership courses / resources design.	Head Of Organisational Development Workforce & Organisational Development	31/03/2026	Progressing
Roll out Compassionate Leadership resources and embed into development programmes	Director of People and Organisational Development	31/03/2027	Progressing
Deliver Culture Change Plan with Comms and Engagement rollout The synthesis report was submitted to EC then P&CC and then board on 27 th November. The report was accepted and endorsed at Board. The next step is to provide a more detailed improvement plan and submit to P&CC for approval. This is expected to have been submitted by 31 st March 26.	Information Manager, Workforce & Organisational Development	31/03/2026	Progressing (revised date from 31/12/2025)
Quarterly Culture, Leadership & Engagement Plans finalised and monitored The-2025/26 plan was in operation and overseen by ODSG. This will be superseded by the 3 year improvement plan noted above	Information Manager, Workforce & Organisational Development	31/03/2027	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at [April 2025](#);

Staff retention is 90.6% In April 2025 compared to 90.2% last year.

	PADR compliance showed improvement increasing to 9.6% The number of Grievance cases has dropped in the previous three months to 3, from a spike of 17 in July 2024. The percentage of stress & anxiety absences remains high at 1.6% although has dropped 0.2% since January. Avoidable turnover has dropped from 5.9% to 4.5% compared to January 2023. Speak out safely cases have dropped from 9 to 6 since the last report in January 2025

CRR 25-08	Risk Title: Non-Compliance with Regulatory and Legislative Requirements	Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Committee Review: 06/11/2025

Date Last Reviewed: 18/12/2025	Director Lead: Director of Corporate Governance	Link to BAF: BAF24-01	Target Risk Date: 30/06/2027
There is a risk that the organisation may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care. This may be caused by inefficiencies in managing regulatory complexities, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements. This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.			
Mitigations/Controls in place		Additional Controls required	
1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Monitoring of regulations and legislation by various groups exist such as: – Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication – Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans. – Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)		a) Improved escalation routes, governance, oversight and monitoring of non-compliance. Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all regulatory activity and inspections (not just clinical) and tracking non-compliance with a clear route for escalation of non-compliance to the EDG and route of escalation. b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary c) The Quality Management system is yet to be fully embedded and will highlight external peer reviews which	



3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legislation.
4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report)

cite any areas of non-compliance for better oversight by the EDG.

- d) Lack of consistent medical device training and local governance
- e) Inadequate workforce capacity in Pharmacy aseptic units; >80% capacity utilisation
- f) Quality assurance and regulatory compliance gaps in Pharmacy services
- g) Net zero / climate compliance delivery plan not embedded (consolidated)
- h) Core Emergency Preparedness policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.

Actions	Action Owner	Due Date	Progression Analysis
A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward) The Executive Committee has agreed the formation of a governance and regulatory group, and work to make the necessary arrangements will continue during February 2026 once TOR (Terms of Reference) and membership approved.	Head of Statutory Compliance and Inquiries	31/03/2026	Progressing (revised date from 01/12/2025)

B) Creation of an electronic system to capture legislative and regulatory information and requirements. On Track: procurement of system underway. System design will take place Jan-Feb, contract awarded and then can be piloted Aug 2026 before being rolled out in Nov 2026.	Head of Statutory Compliance and Inquiries	01/11/2026	Progressing
D) Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required. Audit completed by end Q2 2025, with report submitted to Executive Committee Q3 2025.	Assistant Director Of Ahps And Health Science, Therapies & Health Science	31/03/2026	Complete
A) Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS (Executive	Assistant Director Of Ahps And Health Science,	16/03/2026	Progressing

Director of Allied Health Professions & Health Science) and COO (Chief Operating Officer) in discussion re way forward.	Therapies & Health Science		
Action on track			
E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required.	Chief Pharmacist, Corporate Office	31/01/2026	Progressing (revised date from 30/11/2025)
Regarding outstanding posts to be recruited to. YMW band 3 to 4 uplifts, still progressing, one post to be appointed to in Jan 2026, due to another member of the team resigning (they were eligible for the band 4) the 2 nd post will need to be advertised again as a staff development role. YG will appoint to the band 3 position in Jan 2025. YGC band 7 post – no change in position from November 2025 update. All other posts recruited to.			
A)Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG.	Head of Local Counter Fraud, Finance	31/03/2026	Progressing (revised date from 31/12/2025)

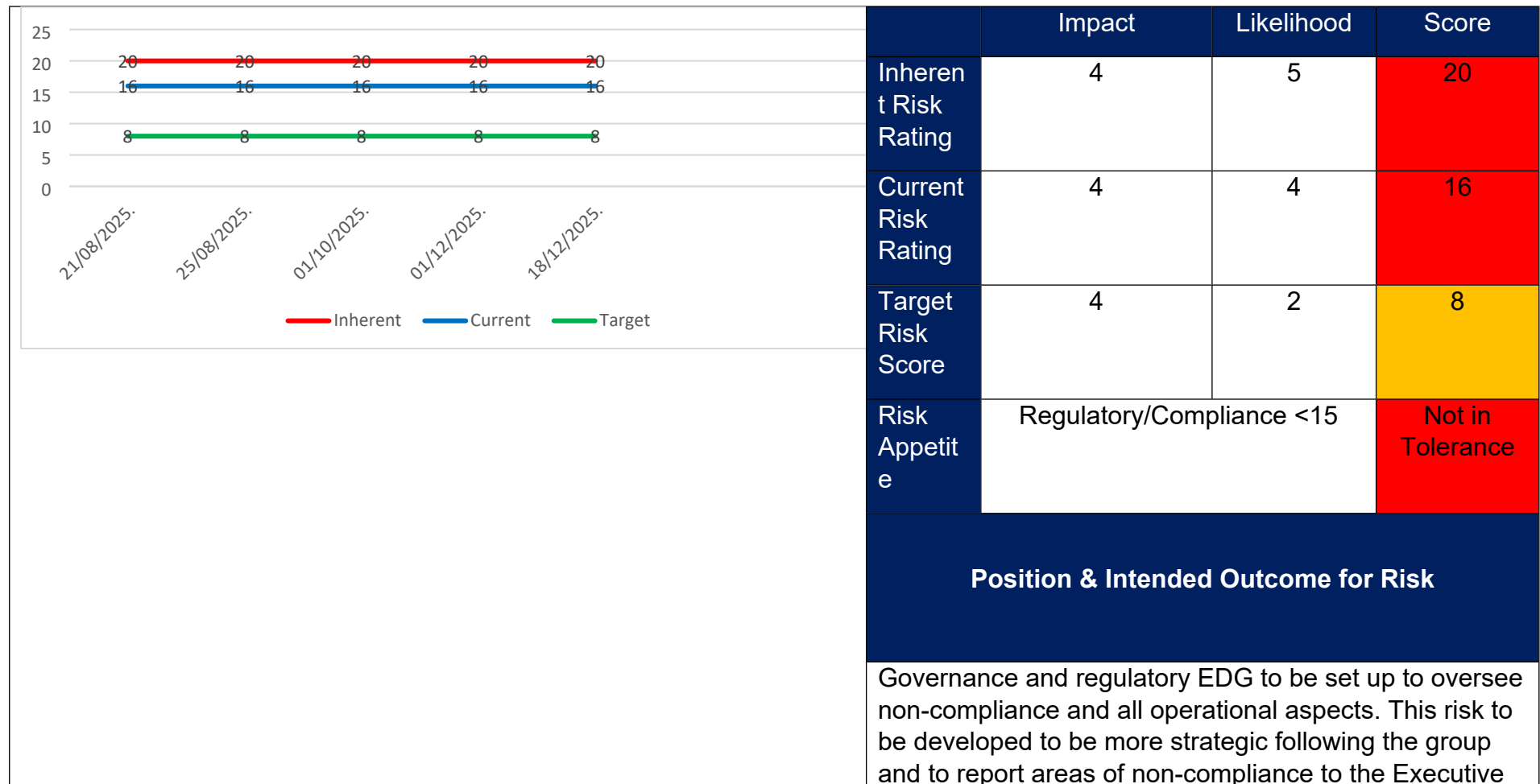


Service currently working at 50% capacity currently due to long term sickness within the team. Some progress made in that risks have been identified and reviewed by Counter Fraud but no risk owner allocated in order for the first task finish meeting to take place.			
Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly. Pharmacy Technical Services business continuity/contingency plans have been reviewed and updated and includes actions to be taken in the event of service failure whether that be a planned or unplanned event.	Chief Pharmacist, Corporate Office	31/12/2025	Complete
h) A number of Business Continuity Plans (BCP) have been identified as in place however scoping is required to identify all outstanding BCPs (possibility of over 100 BCP, however scoping is required to determine). Continue support is required for the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting, monitoring and compliance rates. The scoping exercise to identify all required BCPs will be completed by March 2026. We have now received a denominator number from IHC Centre (46). We are now working with individual services offering supporting workshops to review/amend	Deputy Head of Emergency Preparedness Resilience & Response	31/03/2026	Complete



and create BCPs, this is across all 6 areas. 3 IHCs, Womens, MH/LD and Corporate. Complete			
h) Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator, to be a control once uptake and communicated out. BCP Dashboard in place and reporting monthly by email to leads and CCAG group members. Complete	Deputy Head of Emergency Preparedness Resilience & Response	31/12/2025	Complete
Ensure the Wholesale Distribution Authorisation (WDA(H)) is upheld to enable the lawful procurement, storage, and supply of medicinal products to organisations outside the Health Board's legal entity The Wholesale Distribution Authorisation (WDA(H)) remains compliant and upheld following the MHRA inspection in November 2025. The inspection has been formally closed with a low site risk rating and a 3–5 year inspection cycle. The MHRA-approved action plan is largely complete, with the Quality Management System strengthened through monthly QMS meetings, formal governance arrangements and standardised agendas. Remaining actions are progressing and are primarily dependent on external factors or sequencing (including an SLA with Mountain Rescue, delivery of calibrated data loggers to enable temperature	MSO/ Lead Governance Pharmacist - Policies	31/03/2026	Progressing

mapping, and completion of governance training), with revised timescales extending into early 2026 where appropriate. Overall, regulatory assurance is strong and outstanding actions are focused on resilience and embedding good practice rather than addressing compliance concerns.			
New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards. In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off.	Head of Health, Safety and Security	31/03/2026	Progressing (revised date from 31/12/2025)
Review Integrated Performance Framework and finalise the redesign of reporting structures/timings to enhance transparency. Due to be updated ahead of March 2026 Board	Director Of Performance	31/03/2026	Progressing
Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System to be approved for procurement 22/12/25, new software in place by 30/04/25 but piloted end of 2026 which will support automated tracking. This will not be embedded until 2026-2027	Head of Statutory Compliance and Inquiries	30/09/2026	Progressing
Executive Team recruitment ongoing with some progress made on appointments. Director of People and OD in progress with interim arrangements in place	Interim Executive Director of People Services and Organisational Development	31/03/2026	Progressing



	Committee. Compliance to be tracked and risks mitigated.

CRR 25-09	Risk Title: Safe Environment		Date Opened: 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 22/10/2025.
Date Last Reviewed: 23/01/2026	Director Lead: Director of Environment and Estates	Link to BAF: BAF 24-03	Target Risk Date: 31/03/2030
There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards. This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estate's strategy. This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.			
Mitigations/Controls in place		Additional Controls required	
- Estates Strategy developed and approved by the Health Board in January 2023. - Internal Governance for capital allocation in place within the Health Board. - Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy		6-facet surveys to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. - Standardised approach by the Health Board in relation to management of Estates and Capital between the	

4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: a. Fire Management b. Asbestos Management c. Water Safety, d. Ventilation Safety e. Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance	Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model. c) Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. d) Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group e) Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC f) Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy. g) Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group h) NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group i) NWSSP Authorising Engineer – Electrical– Audit on Electrical Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group



10. Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance
11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.
12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.
13. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board's approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group
14. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination

Actions		Action Owner	Due Date	Progression Analysis



a.) 6-Facet Survey Undertake actions to deliver a 6-facet survey across the Health Board over the next 5 years. Due to financial constraints within the Health Board a review of the 6-facet survey programme is being undertaken to confirm which facets are a priority for the Health Board. Facet 1 - Physical Condition Survey (Fabric and M&E) Facet 2 - Statutory Requirements (Risk Based Methodology for Establishing and Managing Backlog) Facet 3 - Functional Suitability Review Facet 4 - Environmental Management Audit Facet 5 - Space Utilisation Facet 6 - Quality of the Environment	Head of Operational Estates	31/03/2027	Progressing
b.) Develop ToR Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	Director of Environment and Estates	31/03/2026	Progressing
c.) Estates Rationalisation Programme Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and	Head of Operational Estates	31/03/2026	Progressing



opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.			
d.) Non-Compliance with Fire Safety Ensure the HB is fully compliant with Fire Safety Infrastructure on all sites (acute and Community) YG - Health Board submitted a PBC to address the Fire Safety and Infrastructure compliance issues on the Ysbyty Gwynedd site through the Welsh Government Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects	Head of Operational Estates	31/03/2030	Progressing

e.) PBC Developments Ensure the HB has a strategic plan of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC	Director of Environment and Estates	31/03/2026	Progressing
f.) BCUHB Estates Strategy Progress with delivering on the Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy.	Director of Environment and Estates	31/03/2026	Progressing
g.) Pan BCUHB Asbestos Management and Control Ensure the Health Board is fully compliant with its duty to manage asbestos by addressing all findings listed within the internal audit review	Head of Operational Estates	31/03/2026	Progressing
h.) Legionella Management and Control Ensure the Health Board is compliant with its statutory duty to manage water systems across the estate by addressing all fundings reported as part of the AE audit of water systems and operational management	Director of Environment and Estates	31/03/2026	Progressing

	Position & Intended Outcome for Risk
	Current Risk score of 20 aims to be reduced to a 12 by April 2035 as a part of a wider Estates strategy. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog. The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the

	implementation of key BCUHB strategies and is a significant risk to the Board. To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2025. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were

	vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.

CRR 25-10	Risk Title: Health and Safety		Date Opened: 21/08/2025
	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 22/10/2025
Date Last Reviewed: 11/12/2025	Director Lead: Director of Environment and Estates	Link to BAF: BAF24-03	Target Risk Date: 31/03/2026
There is a risk that the organisation will not maintain a safe environment for staff and patients in line with health and safety legislation. This may be caused by inadequate oversight of health and safety risks, gaps in estates and equipment compliance, and insufficient resources to address safety priorities. This may lead to patient and staff harm, enforcement action, reputational damage, and increased legal claims			
Mitigations/Controls in place		Additional Controls required	
1. Gap Analysis has been reviewed. Strategy and plan to March 2026.		a) A review of resources required following the internal audit.	



2. NHS Employer Health and Safety Standards are being developed 3. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 4. Health and Safety eLearning and short courses in place. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.	b) BCUHB Executive Team and Board of Directors to complete health and safety training. c) The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed d) Investment in training venues is required for manual handling training delivery. e) Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training. f) Review of health and safety policies within the next 12-24 months. g) A Health and Safety Risk Assessment and Management Framework needs developing. h) A pan BCUHB Health, Safety and Security Training Needs Analysis is required. i) Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. j) Intranet pages for Health, Safety and Security Services require development.		
Actions	Action Owner	Due Date	Progression Analysis
Develop a Health Board Health and Safety Management Framework. The introduction of the NHS Employer’s Health and Safety Standards will provide an indication of Health & Safety performance and be a mechanism to monitor the Health Board Health & Safety management	Head of Health, Safety	31/12/2025	Complete



framework and will be used to formulate strategy moving forwards. Key service objectives will be monitored going forward. Standards and guidance are available; resources and stakeholder engagement will be secured through the Health & Safety governance structure. Supports compliance, improves governance, and provides a structured mechanism for monitoring and continuous improvement of health and safety performance. Framework to be developed, approved, and implemented by April 2025 with first performance report issued by June 2025. This is complete. The standards are in use and the Health and Safety Team are completing the second Cohort of the self-assessment exercise that this action is built around. Paper went to Executive Committee 12/11/2025 and People and Culture Committee 04/12/2025.	and Security		
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA (Service level agreement) and Technical specification awaiting sign off. Extension to due date requested. Tender delayed due to governance timetable and hampered by Christmas break, and legal obligations under TUPE, which means 4-week consultation and 12-week notice period cannot commence until after 26/03/2025. Secure sign-off for SLA extension, publish tender documentation, complete TUPE consultation (4 weeks) and notice period (12 weeks), and award the new contract. Dependencies include governance approval and TUPE legal obligations; timelines adjusted to accommodate these requirements. Ensures continuity of security services and compliance with legal and governance obligations while transitioning to a new provider. Obtain SLA extension sign-off by 14/01/2026, award new contract by 01/08/2026.	Director of Estates	01/08/2026	Progressing (revised date from 31/03/2026)

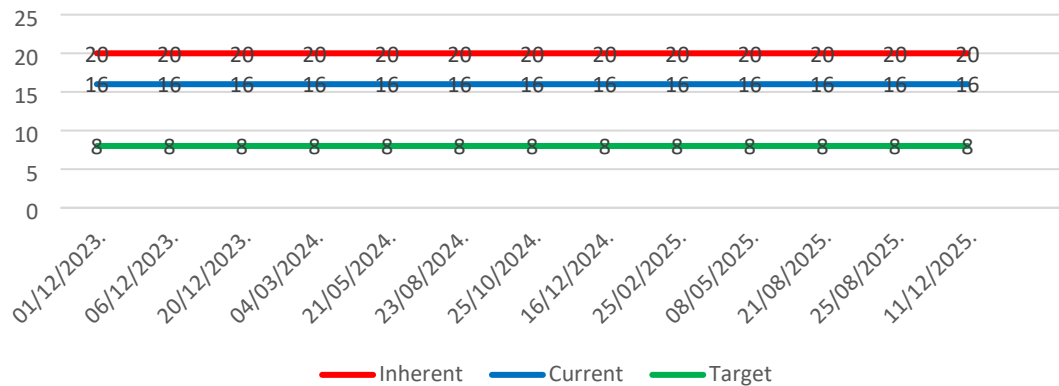
A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle. Complete see action point 1 above and the paper that went to EC (Executive Committee) and P&CC (People & Culture Committee)	Director of Estates	31/12/2025	Complete
A review of resources within the Health, Safety and Security Service is required following the internal audit findings. Produce a documented resource review paper and proposed structure for Leadership consideration, and a completed business case if necessary ready for approval. Initial structure review and remodelling completed; progress dependent on the outcome of the Foundations for the Future program, which will inform final decisions. Address audit recommendations, ensures adequate resourcing, and supports delivery of Health & Safety objectives across BCUHB. Complete the resource review and business case by September 2026, following confirmation of Foundations for the Future outcomes.	Director of Estates	30/09/2026	Progressing (revised date from 31/12/2025)
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Following meeting with DDoNs (Deputy Director of Nursing) and Service Leads, further meetings scheduled to discuss bespoke service requirements. Complete a gap analysis and produce a revised business model document that addresses bespoke service requirements, with sign-off from all relevant stakeholders. Initial meetings with DDoNs and Service Leads have taken place; further meetings are scheduled to gather detailed requirements and ensure feasibility. Supports compliance with national standards and improves consistency in manual handling	Director of Estates	31/08/2026	Progressing (revised date from 31/07/2025)

training and practice across BCUHB. Finalise and approve the revised business model by August 2026, following stakeholder engagement and review.				
Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and risk management documentation. Ensure 100% of health and safety risk assessments, compliance reports, and key documentation are uploaded and accessible through the EDMS within 12 months of go-live. Risk Management software is already approved; project team and resources will be allocated by Head of Health, Safety and Security for the health and safety element to support implementation. Improves transparency of health and safety risks, enhances visibility, and reduces non-compliance by enabling easy access and sharing of documentation. Complete EDMS implementation and staff training by December 2026 , with full operational use from January 2027 .		Director of Estates	01/01/2027	Progressing
		Impact	Likelihood	Score
Inherent Risk Rating		4	5	20
Current Risk Rating		4	4	16



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance
Position & Intended Outcome for Risk			
There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training.			

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

Audit Committee

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

Dyddiad y Cyfarfod Date of Meeting	12 February 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 Approval

Crynodeb Gweithredol **Executive Summary**

This paper presents proposed updates to the Health Board's **Governance and Accountability Framework**, including revisions to the **Scheme of Reservation and Delegation (SORD)**. The changes aim to improve clarity, consistency, and alignment with organisational. There are **no changes** to the Standing Orders and the Standing Financial Instructions but these are included as appendices as they need to be reviewed annually.

Key updates include:

- Updated job titles.
- Changes to approval thresholds for income contracts with non-NHS bodies
- Inclusion of existing approval processes for non-contracted activity for healthcare services

These revisions support the Health Board's strategic objectives and enhance governance arrangements to ensure robust, transparent, and accountable decision-making.

The Executive Committee has supported the changes; and agreed to review the process around the Complex Care Panel and this will be reviewed in advance of the Board in March 2026.

**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
Head of Corporate Governance and Senior Financial Accountant – Charitable Funds and Financial Governance	06/02/26	Reviewing and finalising changes to the Governance Framework
Executive Committee	11/02/2026	Approved

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

1. Y SEFYLLFA SITUATION

- 1.1 At the Board Meeting in September 2025 a comprehensive update was approved on the **Scheme of Reservation and Delegation (SoRD)** and associated **Standing Financial Instructions (SFIs)**. Following implementation of the approved revised SoRD, colleagues have identified a number of queries in relation to Schedule 1 - Scheme of Delegation and Reservation of Powers.

2 Y CEFNDIR BACKGROUND

- 2.1 Recent internal reviews and feedback identified inconsistencies and outdated terminology, and also some ambiguity in approval routes within the current SoRD.

- Several pages required updates, including references to departments/directorates, job title corrections and clarification of delegated limits below £250k.
- Additional sections have been included for income contracts with Local Authorities and Public Bodies, and also non-contracted healthcare activity processed outside of Oracle.
- Previous SoRD versions (e.g., 2023 SoRD) were used to inform improvements where gaps were identified - particularly around non-contracted activity.

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

Proposed changes are highlighted in Appendix 2, Schedule 1 - Scheme of Delegation and Reservation of Powers these are summarised as follows:

- 3.1 **Multiple technical corrections** have now been completed (e.g., job titles, missing words, terminology corrections).
- 3.2 **Governance clarity improvements** are required to reduce confusion — particularly around approval routes, delegated limits and approval thresholds below £250k and responsibilities of Tier 3/4 officers.
- 3.3 **Income tables (Local Authority contracts)** and **approval tables** needed amendment to ensure accuracy and consistency.
- 3.4 **New content areas**, such as travel and subsistence and non-contracted healthcare service activity, have been added where missing from previous versions.
- 3.5 The updates are largely **formatting and clarification**, with a small number requiring **formal committee approval** (e.g., proposed changes to delegated limits or references affecting the governance framework).

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

There are no risks or matters for escalation.

5 **ARGYMHELLION RECOMMENDATIONS**

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

- **APPROVE** the proposed changes to the Scheme of Reservation and Delegation (SoRD) for onward approval at the Board in March 2026.

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	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		
Public Sector Equality Duty:	Do/Yes: ☐	Naddo/No: ☒
Compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES	Canlyniad/Outcome:	
<i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Human Rights Act <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to the Welsh Language requirements?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to giving 'due regard' to the principles of the Armed Forces Covenant <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Socio-economic disadvantage <i>Have you exercising your duties in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
<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 Choose an item.	Meysydd Ansawdd Domains of Quality Effective
	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny:	Not required



	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: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
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:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not 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.	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Standing Orders

Reservation and Delegation of Powers

Betsi Cadwaladr University Health Board

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Standards of Business Conduct Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Director of Corporate Governance/Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

Further information on governance in the NHS in Wales may be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>.

Contents –

▪ Foreword	2
▪ Section A – Introduction	8
▪ Statutory Framework	8
▪ NHS Framework	11
▪ Local Health Board Framework	12
▪ Applying Standing Orders	13
▪ Variation and Amendment of Standing Orders	13
▪ Interpretation	13
▪ The role of the Director of Corporate Governance/Board Secretary	14
▪ Section B – Standing Orders	15
▪ 1. THE LOCAL HEALTH BOARD	15
▪ 1.1 Membership of the Local Health Board	15
▪ <i>Officer Members [to be known as Executive Directors]</i>	15
▪ <i>Non Officer Members [to be known as Independent Members]</i>	16
▪ <i>Associate Members</i>	16
▪ <i>Use of the Term ‘Independent Members’</i>	16
▪ 1.2 Joint Directors	16
▪ 1.3 Tenure of Board Members	17
▪ 1.4 The Role of the LHB Board and Responsibilities of Individual Members	17
▪ <i>Role</i>	17
▪ <i>Responsibilities</i>	18
▪ 2. RESERVATION AND DELEGATION OF LHB FUNCTIONS	19
▪ 2.1 Chair’s Action on Urgent Matters	20
▪ 2.2 Delegation of Board Functions	20
▪ 2.3 Delegation to Officers	20
▪ 3. COMMITTEES	21
▪ 3.1 LHB Committees	21
▪ <i>Use of the Term ‘Committee’</i>	21
▪ 3.2 Joint Committees	21
▪ <i>Joint Committee Standing Orders, Terms of Reference and Operating Arrangements</i>	22
▪ 3.3 Sub-Committees	22
▪ 3.4 Committees Established by the LHB	23
▪ Quality and Safety	23
▪ Audit	23
▪ Information Governance	23

▪ Charitable Funds	23
▪ Remuneration and Terms of Service	23
▪ Mental Health Act requirements.	23
▪ 3.5Other Committees	24
▪ 3.6Confidentiality	24
▪ 3.7Reporting Activity to the Board.....	24
▪ 4. NHS WALES SHARED SERVICES PARTNERSHIP	24
▪ 5. ADVISORY GROUPS	25
▪ 5.1Terms of Reference and Operating Arrangements	25
▪ 5.2Support to the Advisory Groups	26
▪ 5.3Confidentiality	26
▪ 5.4Advice and Feedback.....	27
▪ 5.5Reporting Activity	27
▪ 5.6THE STAKEHOLDER REFERENCE GROUP (SRG)	27
▪ <i>Role</i>	27
▪ 5.7Relationship with the Board.....	28
▪ 5.8Relationship between the SRG and Others	28
▪ 5.9Working with Llais	29
▪ 5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF).....	29
▪ <i>Role</i>	29
▪ 5.11 Terms of Reference and Operating Arrangements	29
▪ 5.12 Relationship with the Board	29
▪ 5.13 Rights of Access to the LHB Board for Professional Groups	29
▪ 5.14 Relationship with the National Professional Advisory Group	30
▪ 5.15 THE LOCAL PARTNERSHIP FORUM (LPF)	30
▪ <i>Role</i>	30
▪ 5.16 Relationship with the Board and Others.....	30
▪ 6. WORKING IN PARTNERSHIP	31
▪ 6.1The Citizen Voice body for health and social care (to be known as Llais	32
▪ <i>Relationship with the Board</i>	33
▪ 7. MEETINGS	33
▪ 7.1Putting Citizens First	33
▪ 7.2Annual Plan of Board Business	34
▪ <i>Annual General Meeting (AGM)</i>	34
▪ 7.3Calling Meetings	35
▪ 7.4Preparing for Meetings	35
▪ <i>Setting the Agenda</i>	35
▪ <i>Notifying and Equipping Board Members</i>	35
▪ <i>Notifying the Public and Others</i>	36
▪ 7.5Conducting Board Meetings	37
▪ <i>Admission of the Public, the Press and Other Observers</i>	37
▪ <i>Addressing the Board, its Committees and Advisory Groups</i>	38

▪ <i>Chairing Board Meetings</i>	38
▪ <i>Quorum</i>	38
▪ <i>Dealing with Motions</i>	39
▪ <i>Voting</i>	40
▪ 7.6 Record of Proceedings	41
▪ 7.7 Confidentiality	41
▪ 8. VALUES AND STANDARDS OF BEHAVIOUR	41
▪ 8.1 Declaring and Recording Board Members' Interests	41
▪ 8.2 Dealing with Members' Interests During Board Meetings	42
▪ 8.3 Dealing with Officers' Interests	44
▪ 8.4 Reviewing How Interests are Handled	44
▪ 8.5 Dealing with Offers of Gifts , Hospitality and Sponsorship	44
▪ 8.6 Sponsorship	46
▪ 8.7 Register of Gifts, Hospitality and Sponsorship	46
▪ 9. SIGNING AND SEALING DOCUMENTS	47
▪ 9.1 Register of Sealing	47
▪ 9.2 Signature of Documents	47
▪ 9.3 Custody of Seal	48
▪ 10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS	48
▪ 10.1 The Role of Internal Audit in Providing Independent Internal Assurance	48
▪ 10.2 Reviewing the Performance of the Board	49
▪ 10.3 External Assurance	49
▪ 11. DEMONSTRATING ACCOUNTABILITY	50
▪ 12. REVIEW OF STANDING ORDERS	50
▪ SCHEDULE 1	52
▪ Model Scheme of Reservation and Delegation of Powers	52
▪ Introduction	53
▪ Deciding What to Retain and What to Delegate: Guiding Principles	54
▪ Handling Arrangements for the Reservation and Delegation of Powers... ..	55
▪ The Board	55
▪ The Chief Executive	55
▪ The Director of Corporate Governance/Board Secretary	55
▪ The Audit Committee	56
▪ Individuals to Who Powers Have Been Delegated	56
▪ Scope of These Arrangements for the Reservation and Delegation of Powers	56
▪ Schedule of Matters Reserved to the Board	57
▪ Delegation of Powers to Committees and Others	65
▪ Scheme of Delegation to Executive Directors, Other Directors and Officers ...	66
▪	
▪	

▪ SCHEDULE 2	67
▪ Key Guidance, Instructions and Other Related Documents	67
▪ LHB Framework.....	67
▪ NHS Wales Framework	67
▪ SCHEDULE 2.1	69
▪ Model Standing Financial Instructions for Local Health Boards	69
▪ SCHEDULE 3	70
▪ Board Committee Arrangements	70
▪ SCHEDULE 4	71
▪ Joint Committee Arrangements.....	71
▪ SCHEDULE 5	72
▪ Advisory Groups	72
▪ Terms of Reference and Operating Arrangements.....	72
▪ SCHEDULE 5.1	73
▪ Stakeholder Reference Group	73
▪ Terms of Reference and Operating Arrangements.....	73
▪ THE STAKEHOLDER REFERENCE GROUP (SRG).....	73
▪ 1.1 Role..	73
▪ 1.2Membership	73
▪ 1.3Member Responsibilities and Accountability	74
▪ <i>The Chair</i>	74
▪ <i>The Vice Chair</i>	75
▪ <i>Members</i>	75
▪ 1.4Appointment and Terms of Office	76
▪ 1.5Resignation, Suspension and Removal of Members	77
▪ 1.6Relationship with the Board.....	78
▪ 1.7Relationship Between the SRG and Others	78
▪ 1.8Working with Llais	78
▪ SCHEDULE 5.2	79
▪ Health Professionals' Forum	79
▪ Terms of Reference and Operating Arrangements.....	79
▪ THE HEALTHCARE PROFESSIONALS' FORUM (HPF)	79
▪ 1.1Role.....	79
▪ 1.2Terms of Reference and Operating Arrangements	79
▪ 1.3Membership	79
▪ 1.4Member Responsibilities and Accountability	80
▪ <i>The Chair</i>	80
▪ <i>The Vice Chair</i>	80
▪ <i>Members</i>	81
▪ 1.5Appointment and Terms of Office	81
▪ 1.6Resignation, Suspension and Removal of Members	82

▪ 1.7Relationship with the Board.....	83
▪ 1.8Rights of Access to the LHB Board for Professional Groups.....	83
▪ 1.9Relationship with the National Professional Advisory Group.....	84
▪ SCHEDULE 5.3	85
▪ LOCAL PARTNERSHIP FORUM ADVISORY GROUP	85
▪ Terms of Reference and Operating Arrangements.....	85
▪ 1.1 Role and Purpose	85
▪ 1.2General Principles	86
▪ 1.3Membership	87
▪ <i>Management Representatives</i>	87
▪ <i>Staff Representatives</i>	87
▪ 1.4Quorum	88
▪ 1.5Officers	88
▪ 1.6Chairs	88
▪ 1.7Joint Secretaries.....	88
▪ 1.8Sub Committees	89
▪ 1.9Management of Meetings	89
▪ APPENDIX 1	90
▪ Six Principles of Partnership Working.....	90
▪ APPENDIX 2	91
▪ Code of Conduct	91
▪ APPENDIX 3	92
▪ List of Recognised Trade Unions/Professional Bodies.....	92

Section A – Introduction

Statutory Framework

- i) The Betsi Cadwaladr University Health Board (the Local Health Board - LHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, “the Establishment Order”.
- ii) The principal place of business of the LHB is – Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW
- iii) All business shall be conducted in the name of Betsi Cadwaladr University Health Board, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.
- iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.
- ix) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** (“The Constitution Regulations”) which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB’s statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511)**.
- v) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven LHBs in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:
 - (a) Specialised services for –
 - (i) Cancer and blood disorders,

- (ii) Cardiac conditions,
- (iii) Mental health and vulnerable groups,
- (iv) Neurosciences, and
- (v) Women and children,
- (b) Services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis
- (c) Emergency medical services,
- (d) Non-emergency patient transport services
- (e) Emergency medical retrieval and transfer services
- (f) NHS 111 services
- (g) Sexual assault referral centres, and
- (h) Other services as directed by the Welsh Ministers

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29))**, which makes provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

- vi) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.
- vii) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- viii) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014)**.
- ix) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also

includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

- x) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.
- xi) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989)**, made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services.

Guidance on the provisions of Part 9 can be found at <https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf>

- xii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:
 - Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
 - Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
 - The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at <https://www.gov.wales/duty-quality-healthcare>

The NHS Duty of Candour statutory guidance 2023 can be found at <https://www.gov.wales/duty-candour-statutory-guidance-2023>

- xiii) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.
- xiv) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.
- xv) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS Framework

- xvi) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.
- xvii) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.
- xviii) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/>

- xix) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.
- xx) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

- xxi) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.
- xxii) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Betsi Cadwaladr University Health Board and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.
- xxiii) LHBs shall ensure that an official is designated to undertake the role of the Director of Corporate Governance/Board Secretary (the role of which is set out in paragraph xxxiii below).
- xxiv) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

- xxv) The SOs of the LHB (together with SFIs and the Standards of Business Conduct Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule 4.*
- xxvi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance/Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Corporate Governance/Board Secretary as soon as they are aware of any circumstance that has not previously been reported.
- xxvii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

- xxviii) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance/Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:
- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
 - The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and
 - A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

- xxix) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance/Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the

case of SFIs).

- xxx) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance/Board Secretary

- xxxi) The role of the Director of Corporate Governance/Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Director of Corporate Governance/Board Secretary acts as the guardian of good governance within the LHB. The Director of Corporate Governance/Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the Director of Corporate Governance/Board Secretary's role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance/Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

- xxxxiv) Further details on the role of the Director of Corporate Governance/Board Secretary within Betsi Cadwaladr University Health Board, including details on how to contact them, are available at [Health Board Members - Betsi Cadwaladr University Health Board \(nhs.wales\)](#)

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

- 1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.
- 1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.
- 1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

- 1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by Non-Executive Members of the Board and the Chief Executive).
- 1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Executive Director of Finance. Officer and non-officer members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

- 1.1.3 A total of 9 (including the Chief Executive), appointed in accordance with the Constitution, Membership and Procedures Regulations, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the

scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

- 1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a nominated current member or employee of a Third Sector organisation within the LHB area; a nominated trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.
- 1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

- 1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.
- 1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:
- Director of Social Services (nominated by local authorities in the LHB area)
 - Chair of the Stakeholder Reference Group
 - Chair of the Healthcare Professionals' Forum
- 1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

- 1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:
- Chair
 - Vice Chair
 - Non Officer Members

unless otherwise stated.

1.2 Joint Directors

- 1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:
- i) Either or both persons may attend and take part in Board meetings;
 - ii) If both are present at a meeting, they shall cast one vote if they agree;
 - iii) In the case of disagreement, no vote shall be cast; and
 - iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

- 1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.
- 1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.
- 1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.
- 1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.
- 1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

- 1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:
- Setting the organisation's strategic direction
 - Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
 - Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

- 1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.
- 1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.
- 1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".
- 1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.
- 1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.
- 1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

- 1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.
- 1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.
- 1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.
- 1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.
- 1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

- 2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.
- 2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:
- i) Schedule of matters reserved to the Board;
 - ii) Scheme of delegation to committees and others; and

- iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

- 2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

- 2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

- 2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

- 2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

- i) By a committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
- ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
- iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

- 2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

- 2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.
- 2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.
- 2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

- 3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

- 3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- Joint-Committee
- Sub-Committee
- Joint Sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

- 3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board

members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committee(s):

- The National Health Service Wales Joint Commissioning Committee (JCC)

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves

such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and

remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

- 3.4.6 Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

- 3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

- 3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

- 3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

- 4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.
- 4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the

views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

- 4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.
- 4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.
- 4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

- 5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.
- 5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*
- 5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

- 5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:
 - The scope of its work (including its purpose and any delegated powers and authority);
 - Membership (including member appointment and removal, role,

responsibilities and accountabilities, and terms and conditions of office) and quorum;

- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Director of Corporate Governance/Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter

dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

5.6.3 The SRG's role is distinctive from that of Llais, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Llais

- 5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.
- 5.9.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

- 5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.
- 5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

- 5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

- 5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 5.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.
- 5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 The LHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance/Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
- ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

- 5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.
- 5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.
- 5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

- 6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.
- 6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:
- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
 - The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.
- 6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future

Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working—implications-for-health-boards-and-NHS-Trusts.pdf

- 6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

- 6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations.

- 6.1.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

- 6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at <https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf>

- 6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

- 6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

<https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people>

- 6.1.6 In discharging these duties, the Board shall work constructively with Llais

to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

The Guidance on Changes to Health Services can be found at <https://www.gov.wales/guidance-changes-health-services>

- 6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

- 6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

- 6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

- 7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;

- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

- 7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or Llais.

7.2 Annual Plan of Board Business

- 7.2.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.
- 7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.
- 7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.
- 7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

- 7.2.5 The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2022/2023]. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

- 7.2.6 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

- 7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.
- 7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

- 7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance/Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.
- 7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance/Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

- 7.4.3 Board members shall be sent an Agenda and a complete set of supporting

papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

- 7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance/Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.
- 7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.
- 7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

- 7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, shall be displayed bilingually (in English and Welsh):
- On the LHB's website, as well as
 - Through other methods of communication as set out in the LHB's communication strategy.
- 7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance/Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

- 7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as Llais and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

- 7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.
- 7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance/Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

- 7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.
- 7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.
- 7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member

disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

- 7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance/Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).
- 7.5.14 **Proposing a formal notice of motion** – Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.
- 7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.
- 7.5.16 **Amendments** - Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.
- 7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.
- 7.5.18 **Motions under discussion** – When a motion is under discussion, any Board member may propose that:
- The motion be amended;
 - The meeting should be adjourned;
 - The discussion should be adjourned and the meeting proceed to

the next item of business;

- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 Rights of reply to motions – The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 Withdrawal of motion or amendments – A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 Motion to rescind a resolution – The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Standards of Business Conduct Policy, or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board, the Standards of Business Conduct Policy will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 **Declaration of interests** – It is a requirement that all Board members must declare any personal or business interests they may have which may

affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Standards of Business Conduct Policy, and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Director of Corporate Governance/Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

- 8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance/Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance/Board Secretary. However, the onus regarding declaration will reside with the individual Board member.
- 8.1.3 **Register of interests** – The Chief Executive, through the Director of Corporate Governance/Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.
- 8.1.4 The register will be held by the Director of Corporate Governance/Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance/Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.
- 8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance/Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.
- 8.1.6 **Publication of declared interests in Annual Report** – Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

- 8.2.1 The Chair, advised by the **Director of Corporate Governance/Board Secretary**, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.
- 8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance/Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.
- 8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:
- i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
 - ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
 - iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
 - iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.
- 8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.
- 8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.
- 8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate

Governance/Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 **Members with pecuniary (financial) interests** – Where a Board member, or any person they are connected with¹ has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define ‘direct’ and ‘indirect’ pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 **Members with Professional Interests** - During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance/Board Secretary.

8.3 Dealing with officers’ interests

8.3.1 The Board must ensure that the Director of Corporate Governance/Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers’ interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts², hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework [**Standards of Business Conduct**] approved by the Board prohibits Board members and

¹ In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

² The term gift refers also to any reward or benefit.

LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance/Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;
- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and
- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items

offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

- 8.6.1 In addition, gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.
- 8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Standards of Business Conduct Policy** and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

- 8.7.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.
- 8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance/Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.
- 8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:
- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
 - **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate'³

³ Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

hospitality need not be included in the Register.

- 8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:
- Acceptance would further the aims of the LHB;
 - The level of hospitality is reasonable in the circumstances;
 - It has been openly offered; and,
 - It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.
- 8.7.5 The Director of Corporate Governance/Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

- 9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.
- 9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

- 9.1.1 The Director of Corporate Governance/Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

- 9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.
- 9.2.2 The Chief Executive or nominated officers may be authorised by the Board

to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

- 9.3.1 The Common Seal of the LHB shall be kept securely by the Director of Corporate Governance/Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

- 10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.
- 10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).
- 10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.
- 10.0.4 Assurances in respect of the functions discharged by the National Health Service Wales Joint Commissioning Committee (the JCC) shall be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.
- 10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

- 10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in

accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own

internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 *[The Director of Corporate Governance/Board Secretary shall arrange for an appropriate impact assessment to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.]*

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

- i) A Committee, e.g., Quality and Safety Committee;
- ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;
- iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and
- iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***
- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***
- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***
- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***
- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***
- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***
- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***
- ***The Board may delegate authority to act, but retains overall responsibility and accountability***
- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance/Board Secretary

The Director of Corporate Governance/Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit⁴ Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Chief Executive of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

⁴ LHB to insert title for the committee that carries out these functions.

SCHEDULE OF MATTERS RESERVED TO THE BOARD⁵

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the NHS Wales Joint Commissioning Committee (the JCC)).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: Items listed on the Board's Cycle of Business
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements

⁵ Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance/Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Standards of Business Conduct Policy
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance/Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital

			investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
23	FULL	OPERATING	Approve the introduction or discontinuance of any significant activity or operation. Any

		ARRANGEMENTS	activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance/Board Secretary
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board
34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property

35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required

49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		This will be developed after consultation with the Chair and CEO
	VICE CHAIR		To be determined when Vice Chair is appointed and in consultation with the Chair
	CHAMPION/ NOMINATED LEAD		To be determined after consultation with the Chair

DELEGATION OF POWERS TO COMMITTEES AND OTHERS⁶

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including [individual LHBs to insert details]

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- **Audit Committee**
- **Charitable Funds Committee**
- **Mental Health and Capacity Compliance Committee**
- **Quality, Safety and Experience Committee**
- **Partnership, People and Population Health Committee**
- **Performance, Finance and Information Governance Committee**
- **Remuneration and Terms of Service Committee**

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the LHB's Scheme of Delegation to Committees.

⁶ As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the LHB's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[LHB to determine]	[LHB to determine] The existing documents will be developed for the Board to consider on 28 Sept 2023 Existing links to current is below Standing Orders and Financial Instructions - Betsi Cadwaladr University Health Board (nhs.wales)

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

LHB framework

The LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs (see Schedule 2.1 below)***
- ***Values and Standards of Behaviour Framework (Standards of Business Conduct Policy)***
- ***Board Assurance Framework (BAF)***
- ***Risk Management Strategy and Policy***
- ***Living Healthier, Staying Well (LHSW)***
- ***Annual Plan***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by:

<https://bcuhb.nhs.wales/about-us/governance-and-assurance/standing-orders-and-financial-instructions/>

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

[please see separate Schedule 2.1 for SFIs]

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders

*[LHB to insert details, including detailed Terms of Reference
and Operating Arrangements for each Committee]*

*Terms of Reference available for all Committees on the Health Board
[website](#)*

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Schedule 4.1 – National Health Services Joint Commissioning Committee

[Appendix A, Document 2: Standing Orders for the NHS Wales Joint
Commissioning Committee](#)

[Appendix A, Document 3: Scheme of Delegation and Reservation of Powers for
the NHS Wales Joint Commissioning Committee](#)

[Appendix B, Document 1: Standing Financial Instructions for the NHS Wales Joint
Commissioning Committee](#)

[Appendix C: Accountability Map](#)

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Schedule 5.1 – Stakeholder Reference Group
Schedule 5.2 – Health Professionals Forum
Schedule 5.3 – Local Partnership Forum

***Terms of Reference available for all Advisory Groups on the Health Board
[website](#)***

Schedule 5.1

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

1.1.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

1.1.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

1.1.3 The SRG's role is distinctive from that of Llais, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

1.1.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member

roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

1.2.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

1.2.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

1.2.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of Llais; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

1.2.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

1.3 Member Responsibilities and Accountability:

The Chair

1.3.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating

arrangements; and

- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Director of Corporate Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.3 As Chair of the SRG, they may as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

The Vice Chair

1.3.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

Members

1.3.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

1.3.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

- 1.3.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

1.4 Appointment and terms of office

- 1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.
- 1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;
- 1.4.3 The Director of Corporate Governance/Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.
- 1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.
- 1.4.5 The **Chair** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.
- 1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.
- 1.4.7 The **Vice Chair** shall be nominated from within the membership of the

SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

- 1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.
- 1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.
- 1.4.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5 Resignation, suspension and removal of members

- 1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.
- 1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:
 - It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
 - It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

- 1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.
- 1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

- i) The absence was due to a reasonable cause; and
- ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.5.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.6 Relationship with the Board

1.6.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

1.6.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

1.6.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

1.6.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

1.7 Relationship between the SRG and others

1.7.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

1.8 Working with Llais

1.8.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

1.8.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Schedule 5.2

Health Professionals' Forum

Terms of Reference and Operating Arrangements

THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

1.1 Role

- 1.1.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.
- 1.1.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

1.2 Terms of reference and operating arrangements

- 1.2.1 The Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

1.3 Membership

- 1.3.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:
 - Welsh Medical Committee
 - Primary and Community Care Medical representative
 - Mental Health Medical representative
 - Specialist and Tertiary Care medical representative
 - Welsh Nursing and Midwifery Committee
 - Community Nursing and Midwifery representative
 - Hospital Nursing and Midwifery representative
 - Welsh Therapies Advisory Committee
 - Therapies representative
 - Welsh Scientific Advisory Committee

- Scientific representative
- Welsh Optometric Committee
 - Optometry representative
- Welsh Dental Committee
 - Dental representative
- Welsh Pharmaceutical Committee
 - Hospital Pharmacists representative
 - Community Pharmacists representative

1.3.2 Where the Board determines it appropriate, the LHB may extend membership to other individuals in order to ensure an appropriate balance in representation amongst healthcare professional groupings and across the range of primary, community and secondary service provision.

1.4 Member Responsibilities and Accountability:

The Chair

1.4.1 The Chair is responsible for the effective operation of the HPF:

- Chairing meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the HPF's membership and between the HPF and the LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

1.4.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Director of Corporate Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the HPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.4.3 As Chair of the HPF, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

The Vice Chair

1.4.4 The Vice-Chair shall deputise for the Chair in their absence for any

reason, and will do so until either the existing chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

- 1.4.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the HPF.

Members

- 1.4.6 The HPF shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the HPF.

- 1.4.7 All members must:

- Be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the HPF within the healthcare professional discipline they represent.

- 1.4.8 Forum members are accountable through the HPF Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

1.5 Appointment and terms of office

- 1.5.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

- 1.5.2 The **Chair** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations

provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

- 1.5.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.
- 1.5.4 The **Vice Chair** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.
- 1.5.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.
- 1.5.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.
- 1.5.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

1.6 Resignation, suspension and removal of members

- 1.6.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.
- 1.6.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:
 - It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member;
 - or

- It is not conducive to the effective operation of the HPF

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

- 1.6.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.
- 1.6.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:
 - i) The absence was due to a reasonable cause; and
 - ii) The person will be able to attend such meetings within such period as the Board considers reasonable.
- 1.6.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.7 Relationship with the Board

- 1.7.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 1.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 1.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.
- 1.7.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

1.8 Rights of Access to the LHB Board for Professional Groups

- 1.8.1 The LHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance/Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:
 - i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping,

e.g., due to the specialist nature of the issues concerned; or

- ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

1.8.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

1.9 Relationship with the National Professional Advisory Group

1.9.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Schedule 5.3

Local Partnership Forum Advisory Group Terms of Reference and Operating Arrangements

1.1 Role and Purpose

- 1.1.1 The LHB Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.
- 1.1.2 At the earliest opportunity, the Board will engage with staff organisations in the key discussions at the LHB Board, LPF and Locality/Divisional level.
- 1.1.3 All members are full and equal members of the forum and collectively share responsibility for the decisions made.
- 1.1.4 The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.
- 1.1.5 The purpose of the LPF will be to:
- Establish a regular and formal dialogue between the Board's Executive and staff organisations on matters relating to workforce and health service issues.
 - Enable employers and staff organisations to put forward issues affecting the workforce.
 - Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
 - Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
 - Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.

- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.
- Appraise and discuss in partnership the Board services and activity and its implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Board and senior management.
- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Board including matters of service re-profiling.
- Negotiate on matters subject to local determination.
- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties
- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

1.1.6 In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the LHB LPF.

1.2 General Principles

1.2.1 The LHB and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

1.2.2 The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency

- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline they represent.

1.2.3 A Code of Conduct is attached as Appendix 2.

1.3 Membership

1.3.1 All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the LHB recognises for collective bargaining. The Trade Union member of the LHB Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

1.3.2 Management will normally consist of the following members of management representatives:

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

1.3.3 Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

Staff Representatives

1.3.4 The Board recognises those staff organisations listed in Appendix 3 for the representation of members who are employed by the organisation.

1.3.5 Staff representatives must be employed by the organisation and

accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

- 1.3.6 Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

1.4 Quorum

- 1.4.1 Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.
- 1.4.2 If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.
- 1.4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

1.5 Officers

- 1.5.1 The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

1.6 Chairs

- 1.6.1 The Management and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups. Supported by the Director of Corporate Governance/Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.7 Joint Secretaries

- 1.7.1 Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation

Chairs.

- 1.7.2 The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

1.8 Sub Committees

- 1.8.1 When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

1.9 Management of Meetings

- 1.9.1 Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.
- 1.9.2 The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Board wide strategic issues and issues that have LHB wide implications shall be referred to the Welsh Partnership Forum via the LHB Board.
- 1.9.3 The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.
- 1.9.4 The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCM)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

STANDING ORDERS

Scheme of Reservation and Delegation of Powers

(Schedule 1 of the Standing Orders)

SCHEME OF RESERVATION AND DELEGATION OF POWERS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Date approved by Health Board:

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board, subject to any directions that may be made by the Welsh Ministers, shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of its aims and objectives. The Board may delegate functions to:

- i) A Committee, e.g., Performance, Finance and Information Governance Committee (PFIG);
- ii) A sub-Committee, e.g., a locality based Performance, Finance and Information Governance (PFIG) Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;
- iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs or Local Authorities established to take forward matters relating to services; and
- iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g., shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in Standing Orders or Standing Financial Instructions.
- The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility
- The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development
- The Board must take appropriate action to assure itself that all matters delegated are effectively carried out
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes
- Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others
- The Board may delegate authority to act, but retains overall responsibility and accountability
- When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in Standing Financial Instructions).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Chief Executive or the Director of Corporate Governance of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD¹

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the NHS Wales Joint Commissioning Committee (the JCC)).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These will be set out within Schedule of Matters Reserved to the Board.
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ Standing Orders; ▪ Standing Financial Instructions; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

¹ Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal.
9	FULL	OPERATING ARRANGEMENTS	Approve the Standards of Business Conduct Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. from Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium-Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.

23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board

34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property
35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

DRAFT FOR BOARD

DELEGATION OF POWERS TO COMMITTEES AND OTHERS²

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Charitable Funds Committee
- Mental Health Legislation Committee
- Quality, Safety and Experience Committee
- Partnership, People and Population Health Committee
- Performance, Finance and Information Governance Committee
- Executive Committee
- Remuneration Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the LHB's Scheme of Delegation to Committees.

² As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

The Chief Executive's Job Description, together with their Accountable Officer Memorandum, sets out their specific responsibilities. The individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the Standing Financial Instructions, form the basis of the LHB's Scheme of Delegation to Officers.

This element of the scheme of delegation only relates to matters delegated by the Board to the Chief Executive and the Executive Directors which are not covered by the Standing Financial Instructions.

Delegated Matter	Table Reference No.
MEETINGS	1
PERSONNEL	2
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	3
REPORTING INCIDENTS TO THE POLICE	4
LEGAL PROCEEDINGS	5
INSURANCE POLICIES AND RISK MANAGEMENT	6
CLINICAL AUDIT	7
PUTTING THINGS RIGHT REGULATIONS	8
SEAL	9
GIFTS & HOSPITALITY	10
DECLARATION OF INTERESTS	11
INFORMATICS AND THE DATA PROTECTION ACT	12
AUTHORISATION OF NEW DRUGS	13
AUTHORISATION OF RESEARCH PROJECTS	14
AUTHORISATION OF CLINICAL TRIALS	15
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	16
REVIEW OF FIRE PRECAUTIONS	17
HEALTH & SAFETY	18
MEDICINES INSPECTORATE REGULATIONS	19
ENVIRONMENTAL REGULATIONS	20
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	21
COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	22
EMERGENCY PLANNING	23
STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	24
APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS	25
HUMAN TISSUE ACT 2004	26
IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R]	27
NURSE STAFFING LEVELS (WALES) ACT 2016	28
WELSH LANGUAGE STANDARD REPORTING	29
CONTROLLED DRUGS ACCOUNTABLE OFFICER	30
UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW)	31

Board Member Responsible (Tiers 2, 3 or 4): in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee, **Executive Director or Executive Team member**. Where there is more than one **Executive Director Team member named** the applicable responsibility is in relation to their individual service area.

Specific Delegation Where Applicable: The intention is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegated beyond this secondary level. This column sets out the delegation flow where relevant. Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area.

Operational Responsibility (Tier 4): – where Matters are delegated to the Operational Divisions, the generic term "Service Director" has been used to identify the Accountable Lead, for example IHC Director, Director of Mental Health, Cancer, and Support Functions. It is also recognised that these Matters are delegated within Health Board Policy and where relevant are directly supported by Finance, People Services and other Support Functions.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Meetings			
a) Calling meetings of the LHB	Chair	Director of Corporate Governance	Not Delegated
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
2. Personnel			
All Matters locally supported by CFO / FD / People			
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Executive Director People and OD	Supported by Members of the Executive Committee	Service Director
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director People and OD	Associate Director People Services	Not delegated
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director People and OD	Deputy Director Workforce & OD / Associate Director of People Services (IHC / PAN BCU / Support Services)	Service Director
d) Travel & subsistence expenses			
Authority to authorise travel & subsistence expenses	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Maintenance of a list of managers authorised to sign payroll and travel expense documentation (and via e-expense systems)	Executive Director People and OD	Deputy Director of Workforce & OD	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
e) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director People and OD	Direct to Operational Services	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Compassionate leave	Executive Director People and OD	Direct to Operational Services	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director People and OD	Direct to Operational Services	Service Director
Leave without pay	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Medical Staff Leave of Absence – paid and unpaid	Executive Director People and OD	Direct to Operational Services	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services	(Tier 4)
Time off in lieu	Executive Director People and OD	Direct to Operational Services	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director People and OD	Direct to Operational Services	(Tier 4)
f) Annualised hours/flexible working hours system-maintenance of adequate records	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
g) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
Return to work part-time on full pay to assist recovery	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director (Tier 4)
Extension of sick leave on full pay	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
h) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director People and OD	Direct to Operational Services	Service Director
Medical staff study leave (UK)	Executive Medical Director / Executive Director People and OD	Direct to Operational Services	(Tier 4)
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Executive Medical Director / Executive Director of Nursing & Midwifery / Executive Director of Therapies & Health Science / Chief Operating Officer	Direct to Operational Services	(Tier 4)
All other study leave (UK)	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
i) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director People and OD	Direct to Operational Services → In accordance with BCUHB policy / approval from the Executive Director People and OD	Service Director
j) Respect & Resolution Procedure	Executive Director People and OD	Direct to Operational Services	(Tier 4)
k) Professional Misconduct/Competence-Medical and Dental Staff	Executive Medical Director / Executive Director People and OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
l) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
m) Formal actions as required under The Performers List	Chief Executive	Executive Medical Director supported Executive Director People and OD and Chief Operating Officer	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy Responsible Officer or Deputy Medical Director
n) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services	Service Director
o) Renewal of Fixed Term Contract	Executive Director People and OD	Direct to Operational Services	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director People and OD	Associate Director of People Services	Service Director for local implementation: Ultimate Approval is via NHS Pensions Agency
q) Disciplinary Procedure (excluding Executive Directors)	Executive Director People and OD	Executive Directors and Members of the Executive Committee	Service Director (Tier 4)
3. Engagement of Staff Not On the Establishment			
a) Non clinical Consultancy Staff	Executive Director of Finance	Supported by Executive Team	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services	(Tier 4)
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
Other Staffing Groups	Executive Director People and OD	Direct to Operational Services	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
4. Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)			
a) Where a criminal offence is suspected	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
b) Criminal offence of a sexual or violent nature	Ex Executive Director of People and OD Executive Director of Workforce & OD	Direct to Operational Services	Service Director for implementation and compliance
c) Arson or theft	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
d) Other	Chief Executive and Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation and compliance
5. Legal Proceedings			
a) Engagement of the LHB's Legal Services	Director of Corporate Governance	Deputy Director for Legal Services	List of officers authorised to instruct Legal Services will be detailed in the Legal Services Policy Out of Hours approval via Gold On-Call.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Approve and sign all documents on behalf of the LHB which will be necessary in legal proceedings	Director of Corporate Governance	Any Director of the Board or the Deputy Director for Legal Services provided such approval is in accordance with advice from a regulated legal professional – all contrary decisions are reserved for the Chief Executive	Not Delegated
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
6. Insurance Policies (incorporating Risk Management)			
Insurance Policies (incorporating Risk Management)	Chief Executive	Executive Director of Finance and Director of Corporate Governance	Not Delegated except for matters relating to the Welsh Risk Pool where the Deputy Director for Legal Services may act
7. Clinical Audit			
Clinical Audit	Chief Executive	Executive Medical Director	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
8. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery / Director of Corporate Governance (for redress, personal injury claims and clinical negligence claims)	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team/Legal Services Team for implementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery	Service Director and Patient and Carer Experience/Complaints Team for implementation
c) Medico – Legal Matters - Co-ordination of their management (including redress, personal injury claims and clinical negligence claims)	Director of Corporate Governance	Deputy Director for Legal Services	Legal Services Team
9. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance	Not Delegated
b) Attestation of seal in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated
c) Signing and sealing documents in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
10. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
11. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
12. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Chief Digital and Information Officer	Data Protection Officer
b) Responsibility for Informatics policy and strategy	Chief Executive	Chief Digital and Information Officer	Service Director
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Chief Executive	Chief Digital and Information Officer	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
13. Authorisation of New Drugs			
Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Executive Committee)	Not Delegated
14. Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)			
Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Executive Medical Director	Director of Research & Development	Service Director (Tier 4)
15. Authorisation of Clinical Trials			
Authorisation of Clinical Trials	Chief Executive	Executive Medical Director	Service Director (Tier 4)
16. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice			
	Chief Executive	Executive Director of Public Health	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
17. Review of Fire Precautions			
Review of Fire Precautions	Chief Executive	Director of Environment and Estates	Not Delegated
18. Health & Safety			
Review of all statutory compliance legislation and Health and Safety requirements (including associated mandatory staff awareness training).	Chief Executive	Director of Environment and Estates	Not Delegated
19. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
20. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Director of Estates and Environment	Not Delegated
21. Cost/Notional Rent/Third Party Developer/Improvement Grants			
All Matters locally supported by CFO / FD			
Approval of all schedules of payments	Chief Executive	Chief Operating Officer	Service Director (Tier 4)
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU Strategy	Chief Executive	Chief Operating Officer and Director of Estates and Environment	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
22. Compliance Lead Roles:			
a) Caldicott Guardian	Chief Executive	Executive Medical Director	Deputy Medical Director
b) Data Protection Officer	Chief Executive	Data Protection Officer	Head of Information Governance
c) Senior Information Risk Owner	Chief Executive	Chief Digital Information Officer	Not Delegated
23. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)			
Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Public Health	Head of Emergency Preparedness Response and Resilience
24. Statutory compliance with respective Legislation			
Individual Board Members responsible for the implementation of respective legislation	Chief Executive	Director of Corporate Governance	Service Director for implementation
25. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.			
Appointment of all Medical and Dental Consultant posts	Board	Chair of ACC's and reported to the People and Culture Committee	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
26. Human Tissue Act 2004			
Compliance with the Human Tissues Act	Chief Executive	Executive Medical Director	Service Director for implementation
27. Ionising Radiation (Medical Exposure) Regulations 2017			
Compliance Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Allied Health Professionals and Health Science / Executive Medical Director	Service Director for implementation
28. Nurse Staffing Levels Act (Wales) 2016			
Compliance with Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
29. Welsh Language Standard Reporting			
Compliance with the Welsh Language Standards	Chief Executive	Executive Director of Allied Health Professionals and Health Science	Service Director for implementation
30. Controlled Drugs Accountable Officer			
Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
31. Upholding Professional Standards in Wales (UPSW)			
Responsible Officer	Executive Medical Director (SRO)	Deputy Medical Director (Deputy Responsible Officer)	Service Director for implementation
Appointing a Designated Board Member	Health Board Chair	Remuneration Committee	Not Delegated

DRAFT FOR BOM

SCHEME OF DELEGATION LINKED TO STANDING FINANCIAL INSTRUCTIONS

Introduction

This Schedule of additional delegations identifies those specific areas within the Standing Financial Instructions which require additional delegations from the Board, Chief Executive and the Executive Director of Finance and other Officers.

This Schedule should not be read in isolation and needs to be used alongside the full set of Standing Financial Instructions at Schedule 3 of Standing Orders.

The following principles will apply:

- i. Financial limits are at the discretion of the Board;
- ii. Each cost centre must have a single approved budget holder who is accountable for ensuring budgets do not overspend and that expenditure is committed within the Health Board's delegated approved levels as detailed in the budget holder signed Accountability Agreement;
- iii. In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items;
- iv. Directors can assign delegated budget holders with approval limits up to £150k at their discretion
- v. These limits apply to requisition authorisation, which is where the control lies;
- vi. In exceptional circumstances, the Chair may have delegated authority on behalf of the Board, and the use of the delegated authority to the Chair must be included in the minutes of the next meeting of the Board;
- vii. Each Director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place but will remain ultimately accountable for their budget. It may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holder's limits;
- viii. The delegations and approval levels apply to all financial activity of the Health Board, irrespective of the income source relating to the expenditure, for example, any ringfenced income and expenditure must still follow this Scheme of Delegation.

Responsibility for **authorising** ~~contracts for the purchase of goods and services (including capital schemes)~~, Service Level Agreements and Memorandum of Understandings, with **non-NHS bodies** are subject to the **maximum** delegated levels of authority **and also other approval requirements and delegations as detailed in the Scheme of Delegation**, as follows:

Financial Delegations

Tier	Authority Delegated to ~~Financial delegation~~	Financial delegation Authority Delegated to	Oracle Approvers
0	Board	Above £1,000,000	Chief Executive following approval by Board and Welsh Government
1	Chief Executive	Up to £1,000,000	Chief Executive
2	Executive Director of Finance	Up to £500,000	Executive Director of Finance
3	Executive Directors	Up to £300,000	Executive Directors
4	Senior Officers (<i>not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Performance and Commissioning; 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 Performance and Commissioning; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment</i>)
5	Assistant / Associate / Deputy Directors or Heads of Service	Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
6	Service Contract Manager or Head of Operations	Up to £50,000	Service Contract Manager or Head of Operations

7	Service Lead or Site / General Manager	Up to £30,000	Service Lead or Site / General Manager
8	Nominated Budget Holder for specific cost centres	Up to £25,000	Nominated Budget Holder for specific cost centres

DRAFT FOR BOARD

1. General Requirements, Overriding Financial Instructions and Financial Provisions and Obligations

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1A	Health Board's must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have the effect as if incorporated in the Standing Orders (SOs).	1.1.1	Board	Director of Corporate Governance working with the Executive Director of Finance to ensure SFIs are in place and agreed by the full Board.
1B	All financial policies ~~procedures~~ must be approved by the Executive Director of Finance and Audit Committee.	1.1.3	Executive Director of Finance Audit Committee	No further delegation
1C	Should any difficulties arise in the interpretation of any of the SFIs then advice of the Director of Corporate Governance ~~Board Secretary~~ and Executive Director of Finance should be sought before acting. The users of SFIs should also be familiar with the provisions of the health boards SOs.	1.1.4	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Executive Directors are responsible for ensuring that their teams are aware of this requirement.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1D	Full details of any non-compliance with SFIs and explanation of the reasons for non-compliance to be reported to the Executive Director of Finance and Director of Corporate Governance ~~Board Secretary~~ .	1.2.1	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Members of the Executive Committee are responsible for ensuring that their teams are aware of this requirement.
1E	Executive Director of Finance and Director of Corporate Governance ~~Board Secretary~~ to refer any matters of non-compliance to the Audit Committee to formally consider the matter. Audit Committee to make proposals to the Board on any action to be taken.	1.2.1	Executive Director of Finance/ Director of Corporate Governance Audit Committee	Finance Director: Commissioning and Financial Planning in the absence of the Executive Director of Finance <u>and</u> the Head of Corporate Affairs in the absence of the Director of Corporate Governance.
1F	The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer must ensure that the health board meets its statutory obligation to perform its functions within the available financial resources.	1.3.1	Board Chief Executive specifically	No further delegation. Guidance on the responsibility of budget holders is set out later in this document.

2. Responsibilities and delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2A	The Board exercises financial supervision and control by: a) Formulating the Medium-Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan (IMTP); b) Requiring the submission and approval of budgets within approved allocations/overall funding c) Defining and approving essential features in respect of important financial policies, systems and controls (including the need to obtain value for money and sustainability); and d) Defining specific responsibilities placed on Board members and Health Board officers, and Health Board committees and Advisory Groups as indicated in the 'Scheme of delegation' document.	2.1.1	Board	Coordination and management of the development of the IMTP - Executive Director of Transformation, Strategic Planning & Commissioning Coordination and development of the MTFP – Executive Director of Finance
2B	Responsibility for the health board's system of internal control.	2.2.2	Chief Executive	Executive Directors are responsible for ensuring adequate systems of internal control are in place across their areas of responsibility.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2C	It is the duty of the Chief Executive to ensure that Board members, health board officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs	2.2.3	Chief Executive	Director of Corporate Governance and Executive Director of Finance are responsible for ensuring all Board members understand their responsibilities. Executive Directors are responsible for ensuring that their teams understand their responsibilities.
2D	The Executive Director of Finance is responsible for: a) Implementing the health board's financial policies and for coordinating any corrective action necessary to further these policies; b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;	2.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Ensuring that sufficient records are maintained to show and explain the health board's transactions, in order to disclose, with reasonable accuracy, the financial position of the health board at any time; and d) Without prejudice to any other functions of the health board, Board members and health board officers, the duties of the Executive Director of Finance include: (i) the provision of financial advice to other Board members and health board officers, and health board committees and Advisory Groups, (ii) the design, implementation and supervision of systems of internal financial control, and (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the health board may require for the purpose of carrying out its statutory duties.			Finance Director: Commissioning and Financial Planning No further delegation
2E	The Executive Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.	2.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2F	All Board members and health board officers, and health board Committees and Advisory Groups, severally and collectively, are responsible for: a) The security of the property of the health board; b) Avoiding loss; c) Exercising economy, efficiency and sustainability in the use of resources; and d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.	2.4.1	All Board members, officers, Committees and Advisory Groups	No further delegation
2G	Any contractor or employee of a contractor who is empowered by the health board to commit the health board to expenditure or who is authorised to obtain income shall be covered by the SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.	2.5.1	Chief Executive	Executive Directors are responsible for ensuring this is understood by contractors working in their area.

3. Audit, Fraud and Corruption, and Security Management

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3A	In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference.	3.1.1	Board	No further delegation. Director of Corporate Governance will support the establishment of the Committee and ensure clear terms of reference are in place.
3B	The Audit Committee will follow the guidance set out in the NHS Wales Audit Committee Handbook. <i>Note: if new or revised guidance is issued in addition to / replacement of the Handbook, the Committee should follow the revised guidance.</i>	3.1.1	Chair of Audit Committee	No further delegation. Chair of Audit Committee to be supported by Director of Corporate Governance.
3C	Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function.	3.2.1 (a)	Chief Executive	Director of Corporate Governance
3D	Ensuring that the Internal Audit function meets the required standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer.	3.2.1 (b)	Chief Executive	Chief Executive to be supported by Director of Corporate Governance Head of Internal Audit

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3E	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	3.2.1 (c)	Chief Executive	Director of Corporate Governance and Executive Director of Finance or Executive Director of People Services and Organisational Development
3F	Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board.	3.2.1 (d)	Chief Executive	Head of Internal Audit and Director of Corporate Governance
3G	The health board's Audit Committee must ensure that a cost-effective external audit service is delivered.	3.4.1	Audit Committee	Director of Corporate Governance and Executive Director of Finance to support the Audit Committee.
3H	The Audit Committee should consider the annual audit plan prepared by the external auditors and the associated fees. The Audit Committee should consider material changes to the annual audit plan.	3.4.3	Audit Committee	No further delegation. Director of Corporate Governance to ensure review scheduled in to the Committee's work programme
3I	The Auditor General's representative should be invited to attend every Audit Committee.	3.4.4	Director of Corporate Governance	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3J	The health board will provide the Auditor General and his representatives with whatever facilities are necessary to facilities audits, including accommodation and access to IT facilities.	3.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
3K	The Chief Executive and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.	3.5.1	Chief Executive and Executive Director of Finance	No further delegation The Executive Director of Finance will be responsible for regular liaison with Counter Fraud Services
3L	The health board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.	3.5.2	Board	Executive Director of Finance to put arrangements in place. Audit Committee to review adequacy of arrangements.
3M	Local Counter Fraud Specialist to provide a written report to the Executive Director of Finance and Audit Committee at least annually, on counter fraud work within the health board	3.5.4	Local Counter Fraud Specialist	No further delegation. Director of Corporate Governance to ensure report scheduled in to the work programme of the Audit Committee.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3N	The health board must participate in the annual National Fraud Initiative. The Audit Committee should consider the health board's participation in additional dataset matching in order to support the detection of fraud across the whole public sector.	3.5.5	Executive Director of Finance Audit Committee	Director of Corporate Governance to ensure review scheduled in to the work programme of the Audit Committee.
3O	The Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.	3.6.1	Chief Executive	Executive Director of Finance, with support from relevant Directors.
3P	The Chief Executive has overall responsibility for controlling and co-ordinating security.	3.6.2	Chief Executive	Executive Director of Finance, with support from relevant Directors.

4. Financial Duties

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4A	The Executive Director of Finance of the Health Board will: a) Prior to the start of each financial year, submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution, including any sums to be held in reserve; b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and d) Regularly update the Board on significant changes to the initial allocation and the application of such funds.	4.2.4	Executive Director of Finance	No further delegation
4B	The Chief Executive has overall executive responsibility for the health board's activities and is responsible to the Board for ensuring that it meets its financial duty to breakeven.	4.2.5	Chief Executive	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4C	The Chief Executive will compile and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan.	4.3.7	Chief Executive	Executive Director of Transformation and Strategic Planning
4D	The Board will: a) Approve the Integrated Medium-Term Plan (IMTP) prior to the beginning of the financial year of implementation. b) Approve a balanced Medium Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan, which meets all probity and value for money requirements; and c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the health board plan is not in place or in balance.	4.3.8	Board	Performance, Finance and Information Governance Committee and the Planning, Population and Health Partnership Committee will scrutinise the draft IMTP and MTFP and make recommendations to the Board.
4E	The Board approved Integrated Medium-Term Plan will be submitted to the Welsh Government in line with the requirements of the Integrated Planning Framework.	4.3.9	Board	Chief Executive on Board's behalf

5. Financial Management and Budgetary Control

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5A	Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board.	5.1.1	Executive Director of Finance	No further delegation
5B	Approval and Delegation of budgets	5.1.1	Board	No further delegation
5Bi	Approval of annual detailed budget for Directorates within budget approved by Board	Local	Executive and Associate Directors	No further delegation
5Bii	Delegation of budgets to budget holders including ensuring the appropriate documentation is completed and returned to the Finance Directorate	Local	Executive and Associate Directors	No further delegation
5Biii	Authorisation of expenditure above budget	Local	Chief Executive	Reported to Audit Committee See Table 5B (1) below
5C	The Chief Executive may delegate, via the Executive Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with Section 33 of the NHS (Wales) Act 2006 (C.42). This delegation must be in writing, in the form of a letter	5.2.1	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	of accountability, and be accompanied by a clear definition of: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports.			
5D	Delegation to include the authority to exercise virement and budget transfers	5.2.1	Chief Executive	Executive Director of Finance See Table 5D (1) below
5E	The Chief Executive, Executive Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.	5.2.2	Chief Executive	Executive Director of Finance Budget Holders
5F	Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance.	5.2.4	Chief Executive <i>[advised by Executive Director of Finance]</i>	No further delegation
5G	All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled and managed appropriately.	5.2.5	Budget Holders	No further delegation
5H	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	5.2.6	Budget Holders	See Table 5H (1) below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5I	The Executive Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.	5.2.7	Executive Director of Finance	Chief Finance Officers

Table 5B (1) - Authority to commit resources above expenditure baselines set within delegated budgets

Ref	Revenue Business Case Value (Total Value)	Approved by:
1	Up to £0.25m	Chief Executive and Executive Director of Finance All approvals retrospectively reported to Executive Committee
2	Above £0.25m, up to £0.5m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee
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
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

Table 5D (1) -Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to Revenue budgets & vice versa
Within own budget* a department	Budget manager*	Executive Director of Finance in liaison with Welsh Government
Within a directorate; between departments: Between Area Teams, Hospital Teams or Corporate Departments*	Executive Director and Chief Finance Officer Relevant Tier 3 or 4 Officer(s)*	
Between Area Teams, Hospital Teams or Corporate Departments directorates: Above Tier 3 or 4 Officer's delegated limit and up to £0.5m	Relevant Tier 3 or 4 Officer(s) Executive Director of both directorates and the Finance Director – Commissioning and Financial Planning	
Between Area Teams, Hospital Teams or Corporate Departments directorates: Above £0.5m and up to £1.0m	Relevant Tier 3 or 4 Officer(s) Executive Director of both directorates and the Executive Director of Finance or Chief Executive	
Between Area Teams, Hospital Teams or Corporate Departments directorates: Above £1.0m	Board	
* Virement requests for increases in STAT (WTE)	*Also require approval of Finance Director: Commissioning and Financial Planning	
Budget transfers between Reserves and delegated budgets	Finance Director: Commissioning and Financial Planning	

Delegated Authority	Between budget lines	Capital to Revenue budgets & vice versa
Notification of virement to Directorate of Finance to ensure budget updated	Individual authorising the virement	

Table 5H (1)

Delegated Matter	Delegated to:	Agreed by:
Delegation of the management of defined Revenue budgets to budget holders: i. Revenue budgets for Clinical Directorates ii. Revenue budgets for Corporate Directorates iii. Reserves	i. Budget Holders ii. Budget Holders iii. Finance Director: Commissioning and Financial Planning	i. Executive Directors ii. Executive Directors iii. Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5J	Monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to the Board as soon as they come to light and the Board shall be advised on any action to be taken in respect of such variances.	5.3.1	Executive Director of Finance	No further Delegation [Finance Director: Commissioning and Financial Planning supports preparation]
5K	Devise and maintain systems of financial management, performance reporting and budgetary control.	5.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
5L	Each Budget Holder is responsible for ensuring that: a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation; b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.	5.3.4	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5M	The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium-Term Financial Plans.	5.3.5	Chief Executive	Executive Director of Finance with Executive and Associate Directors
5N	All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.	5.5.2	Chief Executive and Executive Director of Finance	No further delegation <i>[if not available these are delegated to their deputies]</i>
5O	All information made available to the Welsh Ministers must be made available to the Board.	5.5.3	Chief Executive and Executive Director of Finance	Director of Corporate Governance

6. Annual Accounts and Reports

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6A	The Board must approve the health board's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.	6.1	Board	No further delegation The Audit Committee will provide advice and make recommendations.
6B	The Chair and Chief Executive have responsibility for signing the accounts on behalf of the health board. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.	6.2	Chair and Chief Executive Chief Executive	No further delegation No further delegation
6C	Ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers and consistent with Financial Reporting Manual and International Financial Reporting Standards.	6.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6D	The health board's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.	6.4	Board	No further delegation <i>[Director of Corporate Governance responsible for ensuring arrangements for a public meeting are made]</i>
6E	The health board will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.	6.5	Board	Director of Corporate Governance to prepare draft for Board consideration.

7. Banking arrangements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7A	The Executive Director of Finance is responsible for managing the Health Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. Health boards are required to use the Government Banking Service (GBS) for its banking services.	7.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7B	Approval of banking arrangements	7.1.2	Board	Audit Committee
7C	The Executive Director of Finance is responsible for: a) Establishing bank accounts; b) Establishing additional commercial accounts (exceptionally); c) Establishing separate bank accounts for the health board's non-exchequer funds; d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; e) ensuring accounts are not overdrawn except in exceptional and planned situations; f) Reporting to the Board all arrangements made with the	7.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	health board's bankers for accounts to be overdrawn; g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.			
7D	All accounts should be held in the name of the health board. No officer other than the Executive Director of Finance shall open any account in the name of the health board or for the purposes of furthering health board activities	7.2.2	Executive Director of Finance	No further delegation
7E	The Executive Director of Finance will prepare detailed instructions on the operation of bank accounts which must include: i) The conditions under which bank accounts are to be operated; ii) Those authorised to sign cheques or other orders drawn on the health board's accounts; iii) Authorised signatories are identified with sufficient seniority, and in the case of e-banking approvers, together with an appropriate approval hierarchy.	7.3.1	Executive Director of Finance	i) Finance Director: Commissioning and Financial Planning ii) See Table 7E (1) below
7F	The Executive Director of Finance must advise the Health Board's bankers in writing of the conditions under which each account will be operated.	7.3.2	Executive Director of Finance	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7G	The Executive Director of Finance shall approve security procedures for any cheques issued without a hand-written signature	7.3.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7H	The Executive Director of Finance will review banking arrangements of the health board at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money.	7.4.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7I	The results of the review should be reported to the Audit Committee.	7.4.1	Executive Director of Finance	Director of Corporate Governance to ensure that such reports go to the Committee.

Table 7E (1)

Day to day operation of bank accounts: i. maintain list of approved signatories for manual payments ii. approval to authorise automated payments: • accounts payable* • payroll • primary care contractors iii. maintain list of bankline users and authorisers for internet banking transactions	i. Finance Director: Commissioning and Financial Planning ii. NHS Wales Shared Services Partnership iii. Finance Director: Commissioning and Financial Planning

***after confirmation from Head of Financial Control that sufficient funds are available in the bank account**

8. Cash, cheques, Payment Cards and other negotiable instruments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8A	The Executive Director of Finance is responsible for: a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; b) Ordering and securely controlling any such stationery with management responsibility given to a duly designated employee; c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; d) establishing systems and procedures for handling cash and negotiable securities on behalf of the health board; e) Ensuring effective control systems are in place for the use of payment cards; f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.	8.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8B	Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance	8.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

DRAFT FOR BC

9. Income, fees and charges

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9A	Designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.	9.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9B	Ensuring that systems are in place for the prompt banking of all monies received.	9.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9C	Approving and regularly reviewing the level of all fees and charges, other than those determined by the Welsh Ministers or by statute (<i>Private patients, overseas visitors, income generation and other related services</i>)	9.3.1	Executive Director of Finance	Head of Healthcare Contracting - Finance
9D	All officers must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.	9.3.2	All Officers of the Health Board	Executive Directors are responsible for ensuring that all their teams are aware of this requirement. Table 9D (1) sets out details of delegations related to fees and charges.

Table 9D (1)

Fees and Charges:	Authority Delegated to
Service Level Agreements / Contracts with other NHS bodies i. Up to £30,000 ii. Up to £50,000 iii. Up to £150,000 iv. Up to £250,000 v. Between £250,000 and £5 million vi. Between £5 million and £10 million vii. Over £10 million	Agreement to provide services with an annual income value up to £250,000 must be provided approved by the Chief Operating Officer and Executive Director of Finance. Above £250,000 must be approved by Executive Committee. SLA / Contracts to be signed in accordance: i. Specific Budget Holders as per operational Schemes of Delegation ii. Service Contract Manager iii. Director / Head of Service iv. Relevant IHC / Service Director v. Relevant Executive Director and Finance Director: Commissioning and Financial Planning vi. Executive Director of Finance or Chief Executive vii. Chief Executive (following approval by the Executive Committee and the Board)
Grant Funding Agreements Agreement to receive a grant with a total income value:	

i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant Directors Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Board and Welsh Government)
Healthcare Agreements / Contracts with Private and 3rd Sector Organisations Authority to sign Agreement to provide services with a total income value over life of contract (following relevant governance approvals): i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Executive Committee and the Board and Welsh Government)
Healthcare Agreements / Contracts with Local Authorities and Public Bodies Authority to sign Agreement to provide services with a total income value over life of contract (following relevant governance approvals):	

i. up to £75,000 ii. up to £250,000 iii. up to £1 million iv. up to £5 million v. over £5 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Executive Committee and the Board and Welsh Government)
Individual NHS patient treatment charges outside of Agreements / Contracts Agreement to provide treatment	Executive Director of Finance
Private Patients and overseas patients without reciprocal agreements i. pricing policy and price structure ii. payment policy, including use of deposits, income guarantees, arrangements with insurance companies	Executive Director of Finance with relevant Director
Commercial sponsorship offers (including funding contributions for staff & non staff costs) Agreement to receive commercial sponsorship or funding (in accordance with the relevant Health Board Policy)	Chief Executive or Executive Director of Finance

Commercial and non-commercial research projects and trials Agreement to receive funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Executive Medical Director and Director of Finance – Commissioning & Financial Planning ii. Executive Medical Director and Executive Director of Finance iii. Executive Director of Finance (following approval by Executive Committee)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9E	The Executive Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place.	9.4.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9F	Ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	9.4.6	Chief Executive & Executive Director of Finance	Finance Director: Commissioning and Financial Planning

10. Non-Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10A	The Chief Executive will approve the level of non-pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the health board's scheme of delegation	10.1.2	Chief Executive	Executive and Service Directors See Table Below for Oracle and non-Oracle requisitions

ALL DIRECTORATES MUST HAVE A LOCAL / OPERATIONAL SCHEME OF DELEGATION LINKING ACTIVITIES TO THE MAXIMUM DELEGATED LIMITS SET OUT BELOW AT A GRANULAR LEVEL OF APPLICATION WITHIN THEIR SERVICE AREA.

All Financial Limits shown below are inclusive of VAT irrespective of recovery arrangements

ORACLE REQUISITIONS	Authority Delegated to
Up to £25,000	Nominated Budget Holder for specific cost centres
Up to £30,000	Service Lead or Site / General Manager
Up to £50,000	Service Contract Manager or Head of Operations

ORACLE REQUISITIONS	Authority Delegated to
Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
Up to £250,000	Service Director including Finance Director: Commissioning and Financial Planning
Up to £300,000	Executive Director
Up to £500,000	Executive Director of Finance
Up to £1 million	Chief Executive
Above £1 million	Chief Executive following approval by the Executive Committee, Board and Welsh Government

Expenditure commitments made outside of the ORACLE requisition process		Authority Delegated to
Contracts for HealthCare Services	See Section 12	See Section 12
Non-contracted activity for Healthcare Services	i. Up to £15,000 ii. Up to £30,000	i. Senior Finance Manager – Healthcare contracts ii. Principal Finance Manager – Healthcare contracts

	iii. Up to £75,000 iv. Up to £500,000 v. Above £500,000	iii. Head of Healthcare Contracting – Finance iv. Executive Director of Finance v. Chief Executive
Staff Travel and Subsistence	TBC	TBC Line Managers
Pension Agency Invoices (Injury Benefit/Compensation)		Executive Director of Finance
Legal costs All claims and defence costs to be supported by formal legal advice	i. Up to £0.5 million ii. Up to £1 million iii. Above £1 million	i. Deputy Director of Legal Services ii. Director of Corporate Governance iii. Chief Executive (following Board approval unless otherwise delegated)
Legal Advice Requests	Chief Executive	Director of Corporate Governance (or Deputy Director of Legal Services) List of officers authorised to instruct approved Legal Services will be detailed in the Legal Services Policy

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10B	The Chief Executive will set out in the operational scheme of delegation and authorisation: a) The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and b) The maximum level of each requisition and the system for authorisation above that level.	10.1.3	Chief Executive	Executive and Service Directors
10C	The Executive Director of Finance will: a) Advise the Board regarding the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs; b) Preparation of instructions and guidance on non-pay expenditure; c) Ensure systems of authorisation are in place; d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable; e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices; f) Be responsible for ensuring compliance with the Public Sector Payment policy; g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation,	10.2.1	Executive Director of Finance	See Table 10C (1) below for competition requirements for 'Goods and Non-Health Services Only' where there is no suitable procurement framework to source the required item(s)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	guidance issued by the Welsh Ministers and SFIs; h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures			
10D	Compliance with the requirements below: a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged; b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement; c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made; d) goods have been duly received, examined and are in accordance with specification and order; e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct; f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or	10.3.1	Budget Holders	Executive Director of Finance to put arrangements to ensure compliance Executive Directors to ensure all budget holders within their Directorate are aware of the requirements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	benefit to Board members or LHB officers, other than: (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, (ii) Conventional hospitality, such as lunches in the course of working visits; g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive; h) All goods, services, or works are ordered on official orders; i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds; j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase.			
10E	The Chief Executive and Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director.	10.3.2	Chief Executive Executive Director of Finance	No further delegation
10F	Prepayments should be exceptional and are only permitted where either:	10.6.1	Executive Director of Finance	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	- The financial advantages outweigh the disadvantages (i.e., cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%); - It is the industry norm e.g., courses and conferences; There is specific Welsh Ministers' approval to do so e.g., voluntary services compact.			
10G	In exceptional circumstances prepayments can be made subject to: a) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Health Board if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments; b) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);	10.6.2	Executive Director of Finance	Executive Directors
10H	The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.	10.6.2 part c)	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10I	Approval for all external consultancy support (total contract value for duration of service) to be approved by Executive Committee. Approvals above £0.5m to also be approved by Board and above £1.0m to be approved by Welsh Government	Local	Executive Committee	As per Table below

Consultancy (Total contract value)	Contract to be signed by
Up to £0.25 million	An Executive Director and Finance Director: Commissioning and Financial Planning (2 to sign)
Up to £0.5 million	Executive Director of Finance or Chief Executive
Up to £1 million	Chief Executive (following Board approval)
Above £1 million	Chief Executive (following approval by Board and Welsh Government)

Table 10C (1) 'Goods and Non-Health Services Only'

Goods/Services/Works (Whole Life Cost Contract Value)	Minimum Competition	Lead	Waivers, or exceptions to tender rules
Below £5,000	Evidence of value for money has been achieved	Budget owners	-
£5,000 to £24,999	Evidence of 3 written quotations	Procurement Services	Executive Director of Finance and NWSSP Procurement Services
£25,000 plus to the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 4 tenders received if available	Procurement Services	Single Tender Action authorised by Executive Director of Finance and Chief Executive
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Procurement Services	Single Tender Action prohibited
Contracts above £1m	Welsh Gov approval required (approval to be obtained at the planning stage)	Procurement Services	-

Notes:

Total value excluding VAT.

Subject to the existence of suitable suppliers

11. Procurement and contracting for goods and services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11A	The health board shall maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes.	11.2.1	Board <i>[Chief Executive is ultimately responsible]</i>	NWSSP Procurement Services
11B	The Procurement Act 2023 and associated subordinate instruments, the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments, and the Welsh Procurement Policy Notices are the key pieces of legislation which governs public sector procurement in the UK. All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with.	11.3.5	Executive Directors	Officers of the Health Board
11C	To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out: a) requirements for, and exceptions to, formal competitive tendering ('Goods and Non-Health Services Only'); b) tendering processes including post tender discussions;	11.5.1	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance

	c) requirements and exceptions to obtaining quotations ('Goods and Non-Health Services Only'); d) evaluation and scoring methodologies; and e) approval of firms for providing goods and services. All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the Health Board's delegation arrangements and approval processes. *	11.5.2		
Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11D	The health board shall develop sustainable procurement solutions consistent with the Wellbeing of Future Generations (Wales) Act 2015 (the WBFG Act 2015). The health board is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains.	11.7.1 11.7.5	Board	No further delegation Executive Director of Transformation, Strategic Planning and Commissioning – to develop on behalf of Board
11E	The health board shall benchmark its performance in sustainable procurement against the Wellbeing of Future Generations (Wales) Act 2015 (WBFG Act 2015). For all contracts over £25,000, the health board shall take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).	11.7.6	Board	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11F	Minimum thresholds for quotes and competitive tendering arrangements for 'Goods and Non-Health Services' are to be complied with.	11.10.2	Executive Director of Finance	All Officers of the Health Board See Table 10(C)1
11G	In exceptional circumstances it may be necessary to secure goods/services/works from a single supplier. In these circumstances a Single Quote / Tender Application (Waiver) must be completed. The Executive Director of Finance must approve such applications up to £25,000; the Chief Executive or designated deputy, and Executive Director of Finance, are required to approve applications exceeding £25,000. This requirement for a Single Quote / Tender Application (Waiver) applies even if the award is a Single Supplier Direct Award under a 'procurement framework'.	11.13	Executive Director of Finance	No further delegation
11H	The relevant budget holder shall oversee and manage each contract on behalf of the health board so as to ensure that obligations on delivery of business and operational objectives, and achieving value for money, are met	11.16.1	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11I	The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the health board. In so doing, the health board's approved catalogue shall be used. Where a required item is not included within the catalogue, advice must be sought from procurement services.	11.18.1	Budget Holders	All individuals authorised to requisition items
11J	Where a required item is not included within the catalogue or on a framework contract, the budget manager shall request procurement services to undertake quotation / tendering exercises ('Goods and Non-Health Services Only') on their behalf.	11.18.2	Budget Holders	All individuals authorised to requisition items
11K	Approval to commence with competition via procurement services (for example, going to tender) must be received in line with this Scheme of Delegation prior to commencement of the competition.	Local	Budget Holders	All individuals authorised to requisition items
11L	All orders for goods ('Goods and Non-Health Services Only') and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.	11.18.3	Budget Holders	All individuals authorised to requisition items

****Current delegated limit for contracts before requiring Ministerial approval is £1m***

12. Health Care Agreements and Contracts for Health Care Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
12A	The Chief Executive is responsible for ensuring the health board enters into suitable Health Care Agreements, or Individual Patient Commissioning Agreements, where appropriate for the provision of health care services from external providers. All agreements must be in accordance with the functions conferred on the Health Board by the Welsh Ministers.	12.1.1 12.1.3	Chief Executive	See Table 12A (1) – 12A (11) below
12A (i)	All Continuing Health Care Pre-Placement Agreements (PPA) are to be approved by the Chief Operating Officer Executive	Local	Chief Executive	No further delegation Chief Operating Officer
12B	The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all Health Care Agreements with external providers.	12.3	Chief Executive	Executive Director of Finance and Director of Performance and Commissioning Director of Corporate Governance to ensure that such reports are built in to work programmes.

	Agreements for the purchase of services	Authority delegated to
12A (1)	Long Term Agreements / Contracts with other NHS bodies Approval and Signing of the Long-Term Agreements (annual renewal of contracts). New agreements / contracts, or any variations to agreement / contracts, are to be approved as per section 12A (2) below	Annual contract schedule approved via annual budget approval process
12A (2)	Service Level Agreements / Contracts with other NHS bodies i. up to £30,000 ii. up to £50,000 iii. up to £150,000 iv. up to £250,000 v. between £250,000 and £5 million vi. between £5 million and £10 million vii. above £10 million	Agreement to purchase services with an annual value up to £250,000 must be approved provided by the Chief Operating Officer and Executive Director of Finance ~~Director of Performance and Commissioning.~~ Annual contract value above £250,000 must be approved by the Executive Committee. Following approval required above, the Agreement / Contract can be signed in accordance: i. Specific Budget Holders as per operational Schemes of Delegation ii. Service Contract Manager iii. Directors / Heads of Service iv. Relevant IHC / Service Director v. Relevant Executive Director and Finance Director: Commissioning and Financial Planning vi. Executive Director of Finance or Chief Executive vii. Executive Director of Finance or Chief

		Executive (following approval at Executive Committee and the Board) All new contracts or variations over £1 million to be retrospectively reported to Board.
	Agreements for the purchase of services	Authority delegated to
12A (3)	Healthcare Agreements / Contracts with non-NHS bodies (Private / 3rd Sector / Grants / Primary Care / Local Authorities) i. up to £75,000 ii. up to £150,000 iii. up to £250,000 iv. between £250,000 and £500,000 v. between £500,000 and £1 million vi. above £1 million (contract on framework) vii. above £1 million (not under any framework)	Agreement to purchase services with a total contract value up to £250,000 over the life of contract must be provided approved by the Executive Director (Tier 3) and Executive Director of Finance (Tier 2) Total contract value above £250,000 must be approved by the Executive Committee. Following approval required above, the Agreement / Contract can be signed in accordance: i. Assistant Directors ii. Associate / Deputy Directors iii. Service Directors iv. Relevant Executive Director and Finance Director: Commissioning and Financial Planning v. Executive Director of Finance or Chief Executive vi. Chief Executive (following approval at Executive Committee, PFIG and the Board) vii. Chief Executive (following approval at Executive Committee, PFIG, Board and from Welsh Government) <i>Note: Welsh Government approval required in</i>

		<i>advance of contract planning</i>
	Agreements for the purchase of services	Authority delegated to
12A (4)	Individual Continuing Health Care (CHC) Placements/Packages - Authorisation of individual placements/packages following recommendation from the 'Local' CHC Panel. APPROVAL REQUIREMENTS EXCLUDES 'FAST TRACK' PROCESS AS PER THE WALES NATIONAL FRAMEWORK Agreement to purchase services with an annual value: i. Up to £125,000 ii. Between £125,000 and £200,000 iii. Between £200,000 and £1 million iv. Above £1 million	For placements above £200,000 per annum, recommendation is required from the Complex, Value for Money and High Risk CHC Panel prior to approval by the Executive Committee i. Service Director and Chief Operating Officer ii. Chief Operating Officer and Executive Director of Finance iii. Executive Director of Finance (following approval at Executive Committee) iv. Chief Executive (following approval at Executive Committee and Board)
12A (5)	Individual Patient Commissioning Agreements (for example, Mental Health Out of Area Placements) Agreement to purchase services with an annual value: i. Up to £125,000 ii. Between £125,000 and £250,000	i. Service Director and Chief Operating Officer ii. Chief Operating Officer and Executive Director of Finance iii. Executive Director of Finance (following approval at Executive Committee)

	iii. Between £250,000 and £1 million iv. Above £1 million	iv. Chief Executive (following approval at Executive Committee and Board)
	Agreements for the purchase of services	Authority delegated to
12A (6)	NHS Funded Nursing Care (FNC) i. Authorisation of individual placements/packages following recommendation from a Nurse Assessor ii. Agreement of changes to annual standard rates	i. IHC Director/Relevant Service Director (Tier 4) ii. Board (following recommendation from Executive Committee)
12A (7)	Individual Patient Funding Requests (IPFR) - Authorisation of individual agreements following recommendation from the IPFR Panel: i. Up to £125,000 ii. Between £125,000 and £299,000 iii. Between £300,000 and £1 million iv. Above £1 million	i. Chair and Vice-chair of BCUHB IPFR Panel ii. Chief Executive iii. Wales IPFR Panel iv. Welsh Government
12A (8)	Primary Care Contracts – General Medical Services (excluding enhanced services) i. Approval and Signing of the GMS contracts with practices ii. Variations to the Agreement iii. Payments under the contracts	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (9)	Primary Care Contracts – General Medical Services (Enhanced services)	

	i. Approval and Signing of agreements to provide Enhanced services ii. Variations to the Agreement iii. Payments under the Agreements	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
	Agreements for the purchase of services	Authority delegated to
12A (10)	Primary Care Contracts – General Dental Services i. Approval and Signing of the GDS contracts with practices ii. Amendments to the Agreement iii. Payments under the contracts	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (11)	Primary Care Contracts – Pharmaceutical Services (including enhanced and advanced services) i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (12)	Primary Care Contracts – General Ophthalmic Services i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (13)	Providing services jointly with Local authorities under Section 32 and 33 of NHS (Wales) Act 2006. i. Approval and Signing of the pooled budget arrangements	As per Table 12A (3) above

	ii. Amendments to the Agreement	

13. Grant funding

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
13A	Maintaining detailed policies and procedures for all aspects of grant funding- i.e., awarding of grants. Where appropriate these should comply with the Welsh Government's Code of Practice to funding the third sector.	13.2.1	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
13B	Health Boards are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.	13.4.3	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
13C	Health Boards are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the	13.4.4	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance

	organisation(s).			
Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
13D	The health board must enter into legally binding funding agreements The health board is responsible for ensuring that all third-party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.	13.4.5 13.4.6	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance

14. Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14A	In accordance with SOs the Board shall establish a Remuneration Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility.	14.1.1	Board	Director of Corporate Governance to ensure Committee in place
14B	The Remuneration Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.	14.1.2	Remuneration Committee Chair Board Chair supported by Director of Corporate Governance	Director of Corporate Governance to ensure reports from the Committee go to the Board No further delegation No further delegation
14C	The Board will, after due consideration and amendment, if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.	14.1.3	Board	People and Culture Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14D	The workforce plans incorporated within the approved Integrated Medium-Term Plan will form the funded establishment, i.e., the budget for all approved posts.	14.2.1	Board to approve	Executive Director of People and Organisational Development All Executive Directors to contribute
14E	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.	14.2.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F	No Board member or health board official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	14.3.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F (i)	Agree acting up salaries for staff a) Staff up to Band 9, within budget. b) Staff Band 9 and above excluding Executive Directors c) Interim Executive Directors	Local	Chief Executive	a) Service Director (Tier 4) supported by Local People Services Team b) Chief Executive c) Remuneration Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14G	Procedures to be presented by the Chief Executive for Board approval for the determination of commencing pay rates, condition of service, etc. for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies.	14.4.1	Chief Executive	Executive Director of People and Organisational Development
14H	The Executive Director of People and Organisational Development has responsibility for securing an efficient, well controlled payroll service.	14.5.1	Executive Director of People and Organisational Development	No further delegation
14I	The Executive Director of People and Organisational Development is responsible for: a) The control framework and detailed procedures which are in place to: - ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments, - reduce the risk of fraud and error within the payroll function. b) Specifying timetables for submission of properly authorised time records and other notifications;	14.5.2	Executive Director of People and Organisational Development	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements; d) Agreeing the timing and method of payment with the payroll service; e) Authorising the release of payroll data where in accordance with the applicable Data Protection Legislation; f) Verification and documentation of data; g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances; h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay; i) Security and confidentiality of payroll information; j) Checks to be applied to completed payroll before and after payment; and k) A system to ensure the recovery from those leaving the employment of the Health Board of sums of money and property due by them to the Health Board.			
14J	The Chief Executive is responsible for: a) Ensuring that any shared or hosted service arrangement is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and audit review procedures; b) Ensuring a sound system of internal control and audit review of any internally provided payroll service;	14.5.3	Chief Executive	a) Director of Corporate Governance b) Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.			c) Finance Director: Commissioning and Financial Planning
14K	Appropriately nominated managers have delegated responsibility for: a) Submitting time records, and other notifications in accordance with agreed timetables; b) Completing time records and other notifications in accordance with the Service Level Agreements; and c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director of People and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance.	14.5.4	Line Managers	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14L	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment	14.6.1	Executive Director of People and Organisational Development	No further delegation

Approve departure under compromise agreement (VERs) - Up to £50k (i & ii) - Above £50k (i, ii & iii)	i. All applications to be approved by Executive Director of People and Organisation Development, Chief Executive and Executive Director of Finance. ii. All applications also need to be approved by the Remuneration Committee iii. Any VER payments over £50k also need to be approved by Welsh Government.
Approve redundancy	Chief Executive and Executive Director of Finance and Remuneration Committee (subject to any Welsh Government approval mechanisms)
Approve departure under compromise agreement (other than VERs)	Executive Director of People and Organisation Development (subject to any Welsh Government approval mechanisms), Chief Executive and Executive Director of Finance

****Note: Any agreements that are deemed contentious to be referred to Remuneration Committee***

15. Capital Plan, Capital Investment, Fixed Asset Registers and Security of Assets

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15A	The Chief Executive is responsible for: (i) ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans; (ii) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; (iii) ensuring that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received; (iv) ensuring that the three-year Capital Plan and detailed annual Capital Programme is approved by the Board, as part of the IMTP, prior to the commencement of the financial year; (v) ensuring the availability of resources to finance all revenue consequences of the investment, including capital charges; and (vi) ensuring that any 3rd party use of NHS estate is properly controlled, reimbursed and reported.	15.4.1	Chief Executive	(i) Executive Director of Transformation and Strategic Planning (ii) Director of Environment and Estates (iii) Executive Director of Finance (iv) Executive Director of Transformation and Strategic Planning (v) Executive Director of Finance (vi) Director of Environment and Estates

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15B	For every capital expenditure proposal, the Chief Executive shall ensure: a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model; b) That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Health Board personnel and external agencies in the process.	15.4.2	Chief Executive	Executive Director of Finance
15C	For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.	15.4.3	Chief Executive	Director of Environment and Estates and Executive Director of Finance
15D	The Chief Executive shall issue to the manager responsible for any scheme: a) Specific authority to commit expenditure; b) Authority to proceed to tender; c) Approval to accept a successful tender.	15.4.5	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15D(i)	Professional advice on recoverable VAT is to be sought on all major Capital Expenditure Programmes. Advice to be sought for the conclusion of each project decision gateway to validate assumptions included within the Business Cases and Plans.	Local	Executive Director of Finance	Head of Capital Finance
15D(ii)	Any movement in contract retention values included in the original contract conditions and award criteria are to be approved by the Executive Committee (unless otherwise delegated)	Local	Executive Committee (unless otherwise delegated)	As delegated by Executive Committee
15E	The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the health board's SOs.	15.4.6	Chief Executive <i>[with advice from Executive Director of Finance]</i>	See below Table 15E (1) Detailed procedures are contained in the Health Board's Capital Manual

Table 15E (1) - Capital Schemes funded by Discretionary Allocation

Discretionary Capital Programme Approvals		Gross Expenditure on Whole Project	
Approval / Sign Off by:	Initial Annual Discretionary Programme	New Approvals Schemes under £500k	Scheme over £500K to £1m
Strategic Planning and Service Change Group (SPSC)			Agree project mandate and priority
Tier 4	Sign Abbreviated Business Case up to £50K	Sign Abbreviated Business Case up to £50K	-
Tier 3 or 4	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case and Business Justification Case
Executive Director / Senior Responsible Officer (Tier 3 or 4)	-	-	Sign Business Justification Case
Executive Director of Finance (Tier 3)	-	-	Review and agreement
Capital Investment Group (CIG)	Recommend	Recommend	Recommend
Strategic Planning and Service Change Group (SPSC)	Recommend for onward consideration for board governance	Approve	Approve Business Justification Case
Performance, Finance and Information Governance Committee (PFIG)	Recommend	-	-
Health Board	Approve	-	-

Capital Schemes funded by Welsh Government

Strategic Planning and Service Change Group (SPSC) considers overall priorities and project mandates in advance of submission to Welsh Government for consideration (Executive approval required). For all-Wales capital schemes, the nature of the business case will be determined in discussion with Welsh Government.

Scheme under £1m	Scheme over £1m
Executive Committee considers overall priorities and project mandates (unless otherwise delegated)	
↓	↓
Scoping document submitted to Welsh Government (WG) followed by a scoping meeting with WG to jointly sign off	Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off
↓	↓
Business Justification Template signed off by lead Senior Responsible Officer and Executive Director	Strategic Outline Case signed off by Strategic Planning and Service Change Group (SPSC), Performance, Finance and Information Governance (PFIG) Committee and the Board
↓	↓
Capital Investment Group Recommend	Outline Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Strategic Planning and Service Change Group Approve	Full Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Submission to WG for approval	Final approval required from WG at each stage of Business Case process

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15F	The Executive Director of Transformation & Strategic Planning and Executive Director of Finance shall issue detailed procedures governing the project, financial management including variations to contract, of capital investment projects and valuation for accounting purposes.	15.4.7	Executive Director of Transformation & Strategic Planning and Executive Director of Finance	See Table 15F (1) below
15G	The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.	15.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
15H	Approval for any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and Third-party Developments, without the consent of the Welsh Ministers.	15.5.1	Welsh Ministers	No further delegation

Table 15F (1)- Capital orders and payment authorisation

ALL CAPITAL SCHEMES TO BE APPROVED AS PER TABLE 15E (1)

Leases over £250,000 are to be approved by the Executive Committee and reported to Performance, Finance and Information Governance (PFIG) committee.

Delegated authority	Variations to Discretionary Schemes	Variations to Capital Schemes funded by WG (within Approved Sum) *	Financial monitoring and reporting responsibility	Enter lease arrangement (all types) total value**
Up to £75k	Head of Capital	Head of Capital	Head of Capital	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £250k	Director of Environment and Estates	Director of Environment and Estates	Director of Environment and Estates	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £500k	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance (following approval by the Executive Committee)
Up to £1 million	Chief Executive	Chief Executive	Chief Executive	Chief Executive (following approval by the Executive Committee)
Above £1 million	Board and Welsh Government (following consideration by PFIG)	Board and Welsh Government	Board and Welsh Government	Chief Executive (following approval by the Executive Committee, PFIG, Board and Welsh Government)

***Any variations to Capital Schemes funded by Welsh Government that exceed the approved sum require further approval from WG**

****All property leases are to be signed under Seal**

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15I	The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Transformation & Strategic Planning and Executive Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically. The Health Board shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance. Additions to the fixed asset register must be clearly identified to the delegated budget holder and be validated by reference to appropriate documentation.	15.6.1 – 15.6.3	Chief Executive	Executive Director of Finance
15J	The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.	15.6.5	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15K	The overall control of fixed assets is the responsibility of the Chief Executive.	15.7.1	Chief Executive	Executive Director of Finance
15L	All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Transformation & Strategic Planning and Executive Director of Finance.	15.7.3	Executive Director of Finance, with support from relevant Directors.	Officers of health board
15M	Approval of routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.	15.7.4	Board All officers of health board	No further delegation

16. Stores and receipt of goods

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16A	i) overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. (ii) The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager (iii) the control of any fuel, oil and coal shall be the responsibility of a designated Estates Manager.	16.2.1	Chief Executive	Executive Director of Finance Chief Pharmacist Director of Environment and Estates
16B	The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.	16.2.2	Executive Director of Finance	Service Directors
16C	Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year.	16.2.4	Executive Director of Finance	Direct to Operational Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16D	Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Finance	16.2.5	Executive Director of Finance	No further delegation
16E	For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance or authorised officer who shall satisfy themselves that the goods have been received before accepting the recharge.	16.3.1	Chief Executive	Executive Director of Finance

17. Disposals and condemnations, losses and special payments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17A	The Executive Director of Finance must prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers.	17.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17B	All unserviceable assets shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Executive Director of Finance. The assets should be recorded on a form indicating whether they are to be converted, destroyed or otherwise disposed of. The form should be countersigned by a second officer authorised for that purpose by the Executive Director of Finance	17.1.3	Executive Director of Finance	Following advice from appropriate heads of service (e.g. IM&T, Estates, etc.) items with original value obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively may be condemned or otherwise disposed of in accordance with the delegations set out in Table 17B (1)

Table 17B (1)

Asset value:	Approved by:
With current/estimated purchase price below < £499	Budget Manager
with current purchase new price above >£500, up to <£5000	Relevant Executive Director
With current purchase new price above >£5,000, up to <£250,000	Executive Director of Finance following approval by the Executive Committee
With current purchase new price above >£250,000	Performance, Finance and Information Governance (PFIG) Committee
Disposal of property or land (all values)	Board and Welsh Government

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17C	The Executive Director of Finance shall ensure procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.	17.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17D	The Executive Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write off' action is recorded on the system.	17.2.8	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17E	The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs.	17.2.9	17.2.9	See Table 17E (1) Below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17F	The Executive Director of Finance shall ensure that all losses and special payments are reported to the Audit Committee at every meeting	17.2.13	Executive Director of Finance	Finance Director: Commissioning and Financial Planning / Director of Corporate Governance

Table 17E (1)

Ratify fruitless payments (including abandoned Capital Schemes)	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £250,000	Chief Executive and Executive Director of Finance
Above £250,000	Chief Executive, Executive Director of Finance and Welsh Government (following Executive Committee approval)

Ratify payment for clinical negligence and personal injury claims where legal advice has been obtained and guidance applied (negotiated settlements) *	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government
Other clinical negligence and personal injury claims where legal advice has not been obtained	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Director of Corporate Governance
Above £50,000	Welsh Government
Authority to write off losses and authorise special payments for bad debts and claims abandoned - private patients, overseas visitors and others.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance

Above £50,000	Welsh Government
Authority to write off damage to buildings, fittings, furniture and equipment, loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, theft, arson) or other.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise compensation payments made under legal obligation (excluding Clinical Negligence and Personal Injury)	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government

Authorise extra contractual payments to contractors.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise ex-gratia payments to patients and staff for the loss of personal effects	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authority to write off Losses of cash due to theft, fraud, overpayment of salaries, wages, fees and allowances	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive and Executive Director of Finance
Above £50,000	Welsh Government

*** For all clinical negligence and personal injury cases (including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more.
All structured settlements require approval from the Welsh Government H&SSG Director of Finance**

18. Digital, Data and Technology

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18A	The health board shall publish and maintain a Freedom of Information (FOI) publication scheme, or adopt a model publication scheme approved by the Information Commissioner.	18.1.2	Board	Chief Digital and Information officer
18B	The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of digital systems and data.	18.2.1	Chief Digital and Information officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18C	The Executive Director of Finance shall ensure that new financial data and systems, and amendments to current financial systems, are developed in a controlled manner and thoroughly tested prior to implementation.	18.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18D	The responsible Director for Digital Data and Technology has responsibility for ensuring that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the i) security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage; ii) availability of the service including resilience for continuity. The contract should also ensure rights of access for audit purposes.	18.4.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18E	Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall periodically seek assurances that adequate controls are in operation.	18.4.2	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18F	The responsible Director for Digital Data and Technology has responsibility for ensuring that the risks to the health board arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including business continuity and disaster recovery plan.	18.5.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18G	All purchases of hardware and software must be undertaken in line with agreed IT policies, Procedures and contractual arrangements.	Requirement in support of SFIs	All Officers	
18H	No purchase or installation may be made of IT software whether new or upgrades to existing systems other than via the IT department	Requirement in support of SFIs	All Officers	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18I	Purchases of routine desktop hardware should be procured via health board contracts. Purchasing of servers should always be via IT	Requirement in support of SFIs	All Officers	

19. Patients' property

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
19A	Ensuring patients or their guardians are informed before or at admission, that the health board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt	19.2.1	Chief Executive Officer	Service Directors
19B	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	19.3.1	Executive Director of Finance	Service Directors
19C	Issuing property valued above >£5,000 only on production of a probate letter of administration	Local	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

20. Funds Held on Trust (Charitable Funds)

The Health Board's Charitable Funds are managed through the registered charity with the Charity Commission (known as Awyr Las) and through the Charitable Funds Committee and its formal Trustee status

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
20A	The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom	20.2.2	Board	See Table 20A (1) below
20B	Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Local	Executive Director of Finance	Head of Fundraising See Table 20A (1) below
20C	Legacies - Authority to accept the discharge of a donor's estate	Local	Executive Director of Finance	Not delegated

Table 20A (1) Access to Charitable Funds

Item	Delegated authority
i. Approval and setting up of designated fund Advisors for new funds. ii. Approval of changes to Fund Advisors	i. Head of Fundraising with advice from relevant Director ii. Head of Fundraising with advice from relevant Director
New Fundraising Appeal: i. Up to £5,000 ii. Above £5,000, up to £25,000 iii. Above £25,000	i. Head of Fundraising with advice from relevant Director ii. Executive Director of Finance iii. Charitable Funds Committee
Expenditure requests for Charitable funds: i. Up to £5,000 (non-contentious) * ii. Above £5,000 and any contentious expenditure* iii. Above £1 million	To be submitted to Charity Team for initial review i. Fund Advisor (subject to confirmation from the Assistant Financial Accountant - Charitable Funds that sufficient funds are available and expenditure complies with Charity guidelines) ii. Charitable Funds Committee iii. Health Board and Welsh Government
Oracle approvals: i. Up to £5,000 ii. Above £5,000, up to £50,000 iii. Above £50,000, up to £250,000	Expenditure over £5,000 is only approved following prior approval by the Charitable Funds Committee i. Assistant Financial Accountant - Charitable Funds ii. Senior Financial Accountant - Charitable Funds iii. Finance Director – Commissioning and Financial

iv. Above £250,000, up to £500,000 v. Above £500,000	iv. Planning Executive Director of Finance v. Chief Executive

****The term “contentious” refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives as detailed in ‘Your Charity Procedures’.***

Investment of Charitable Funds

Investments Authority	
Investment of funds i. Decision on nature and value of investment ii. Risk level of investment fund	i. Charitable Funds Committee with guidance from Executive Director of Finance ii. Charitable Funds Committee with guidance from Executive Director of Finance and appointed investment managers

*****The term “investment” refers to stocks, shares, bonds, property, unit funds or other instruments derived to generate a rate of return and/or valuation gains, other than interest bearing bank accounts***

21. Retention of Records

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
21A	The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of information Act 2000 (c.36).	21.1.1	Chief Executive	Chief Digital and Information officer / Executive Medical Director
21B	Approval for the destruction of records	Local	Chief Executive	Chief Digital and Information officer / Executive Medical Director

Schedule 2.1

STANDING FINANCIAL INSTRUCTIONS FOR BETSI CADWALADR UNIVERSITY HEALTH BOARD

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Model Standing Orders, Reservation and Delegation of Powers for LHBs
Schedule 2.1: Standing Financial Instructions

Status: Approved Board 25.09.25 V1.0

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Executive Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Director of Corporate Governance will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>

Contents

Foreword

1. INTRODUCTION

- 1.1 General
- 1.2 Overriding Standing Financial Instructions
- 1.3 Financial provisions and obligations of LHBs

2. RESPONSIBILITIES AND DELEGATION

- 2.1 The Board
- 2.2 The Chief Executive and Director of Finance
- 2.3 The Director of Finance
- 2.4 Board members and LHB officers, and LHB Committees and Advisory Groups
- 2.5 Contractors and their employees

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

- 3.1 Audit Committee
- 3.2 Chief Executive
- 3.3 Internal Audit
- 3.4 External Audit
- 3.5 Fraud and Corruption
- 3.6 Security Management

4. FINANCIAL DUTIES

- 4.1 Legislation and Directions
- 4.2 First Financial Duty – The Breakeven Duty
- 4.3 Second Financial Duty – The Planning Duty

5 FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

- 5.1 Budget Setting
- 5.2 Budgetary Delegation
- 5.3 Financial Management, Reporting and Budgetary
- 5.4 Capital Financial Management, Reporting and Budgetary Control

5.5 Reporting to Welsh Government - Monitoring Returns

6. ANNUAL ACCOUNTS AND REPORTS

7. BANKING ARRANGEMENTS

- 7.1 General
- 7.2 Bank Accounts
- 7.3 Banking Procedures
- 7.4 Review

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

- 8.1 General
- 8.2 Petty Cash

9. INCOME, FEES AND CHARGES

- 9.1 Income Generation
- 9.2 Income Systems
- 9.3 Fees and Charges
- 9.4 Income Due and Debt Recovery

10. NON-PAY EXPENDITURE

- 10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability
- 10.2 The Director of Finance's responsibilities
- 10.3 Duties of Budget Holders and Managers
- 10.4 Departures from SFI's
- 10.5 Accounts Payable
- 10.6 Prepayments

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

- 11.1 Procurement Services
- 11.2 Policies and Procedures
- 11.3 Procurement Principles
- 11.4 Procurement Regulations and Legislation Governing Public Procurement
- 11.5 Procurement Procedures
- 11.6 Procurement Consent
- 11.7 Sustainable Procurement

Schedule 2.1: Standing Financial Instructions

- 11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)
 - 11.9 Planning Procurements
 - 11.10 Procurement Process
 - 11.11 Procurement Thresholds
 - 11.12 Designing Competitions
 - 11.13 Single Quotation Application or Single Tender Application
 - 11.14 Disposals
 - 11.15 Evaluation, Approval and Award
 - 11.16 Contract Management
 - 11.17 Extending and Varying Contracts
 - 11.18 Requisitioning
 - 11.19 No Purchase Order, No Pay
 - 11.20 Official orders

 - 12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES**
 - 12.1 Health Care Agreements
 - 12.2 Statutory provisions
 - 12.3 Reports to Board on Health Care Agreements (HCAs)

 - 13. GRANT FUNDING,**
 - 13.1 Legal Advice
 - 13.2 Policies and procedures
 - 13.3 Corporate Principles underpinning Grants Management
 - 13.4 Grant Procedures

 - 14. PAY EXPENDITURE**
 - 14.1 Remuneration and Terms of Service Committee
 - 14.2 Funded Establishment
 - 14.3 Staff Appointments
 - 14.4 Pay Rates and Terms and Conditions
 - 14.5 Payroll
 - 14.6 Contracts of Employment

 - 15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**
 - 15.1 Capital Plan
 - 15.2 Capital Investment Decisions
-

Schedule 2.1: Standing Financial Instructions

- 15.3 Capital Projects
- 15.4 Capital Procedures and Responsibilities
- 15.5 Capital Financing with the Private Sector
- 15.6 Asset Registers
- 15.7 Security of Assets

- 16. STORES AND RECEIPT OF GOODS**
 - 16.1 General position
 - 16.2 Control of Stores, Stocktaking, condemnations and disposal
 - 16.3 Goods supplied by an NHS supplies agency

- 17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**
 - 17.1 Disposals and Condemnations
 - 17.2 Losses and Special Payments

- 18. DIGITAL, DATA and TECHNOLOGY**
 - 18.1 Digital Data and Technology Strategy
 - 18.2 Responsibilities and duties of the responsible Director
 - 18.3 Responsibilities and duties of the Director of Finance
 - 18.4 Contracts for data and digital services with other health bodies or outside agencies
 - 18.5 Risk assurance

- 19. PATIENTS' PROPERTY**
 - 19.1 LHB Responsibility
 - 19.2 Responsibilities of the Chief Executive
 - 19.3 Responsibilities of the Director of Finance

- 20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)**
 - 20.1 Corporate Trustee
 - 20.2 Accountability to Charity Commission and the Welsh Ministers
 - 20.3 Applicability of Standing Financial Instructions to funds held on Trust

- 21. RETENTION OF RECORDS**
 - 21.1 Responsibilities of the Chief Executive

Schedule 1

Schedule 2.1: Standing Financial Instructions

Betsi Cadwaladr University Health Board

1. INTRODUCTION

1.1 General

- 1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1 of SOs).
- 1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Betsi Cadwaladr University Health Board (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.
- 1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes.
- 1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Corporate Governance or Executive Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

1.2 Overriding Standing Financial Instructions

- 1.2.1 Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Executive Director of Finance and the Director of Corporate Governance, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members

Schedule 2.1: Standing Financial Instructions

and LHB officers have a duty to report any non-compliance to the Executive Director of Finance and Director of Corporate Governance as soon as they are aware of any circumstances that has not previously been reported.

- 1.2.2 Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of LHBs

- 1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

- a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);
- b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding
- c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and
- d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

2.2 The Chief Executive and Executive Director of Finance

2.2.1 The Chief Executive and Executive Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial

provisions, obligations and targets are met; and has overall responsibility for the LHB's system of internal control.

- 2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Executive Director of Finance

- 2.3.1 The Executive Director of Finance is responsible for:

- a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;
- b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and
- d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Executive Director of Finance include:
 - (i) the provision of financial advice to other Board members and LHB officers, and LHB Committees and Advisory Groups,
 - (ii) the design, implementation and supervision of systems of internal financial control, and
 - (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

- 2.3.2 The Executive Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to effect these SFIs.

2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

- 2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

Schedule 2.1: Standing Financial Instructions

- a) The security of the property of the LHB;
- b) Avoiding loss;
- c) Exercising economy, efficiency and sustainability in the use of resources; and
- d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB Committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, Committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

- 3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manualdocuments/useful-documents/nhs-wales-audit-committee-handbookjune-2012/

3.2 Chief Executive

- 3.2.1 The Chief Executive is responsible for:

- a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
- b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

- c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:
 - a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

Schedule 2.1: Standing Financial Instructions

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation without necessarily giving prior notice to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) Access at all reasonable times to any land or property owned or leased by the LHB;
- c) Access at all reasonable times to Board members and LHB officers;
- d) The production of any cash, stores or other property of the LHB under a Board member or a LHB official's control; and
- e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

- 3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB. The Auditor General may nominate his representative to represent him within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.
- 3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:
- a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;
 - b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report ¹;
 - c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.
- 3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.
- 3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion

¹ Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

on the annual report and accounts, is central to the core work of the Audit Committee.

- 3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.
- 3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.
- 3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs that relate to the exercise of many of his core functions, including his statutory audit of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the LHB and its officers and staff, but also to, among others, suppliers to the LHB.
- 3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the LHB (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the LHB may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

- 3.4.9 The Auditor General will issue a number of reports over the year, some

Schedule 2.1: Standing Financial Instructions

of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. At LHBs he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

<https://nwssp.nhs.wales/a-wp/governance-e-manual/knowning-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/>

3.5.3 The LCFS shall report to the LHB Executive Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS

Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

- 3.5.4 The LCFS will provide a written report to the Executive Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the LHB.
- 3.5.5 The LHB must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The LHB should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

- 3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.
- 3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular “WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts.” They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.1.2 The details and requirements for the two duties are set out in the Welsh Health Circular “WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts.”

Full details of the WHC can be obtained by contacting the HSSG Director of Finance

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Health Board has a statutory duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 Welsh Government will determine revenue and capital allocations prior to the start of each financial year and notify Health Boards.

4.2.3 Health Boards must ensure their boards approve balanced revenue and capital plans in line with their notified allocations before the start of each financial year.

4.2.4 The Executive Director of Finance of the LHB will:

- a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed

Schedule 2.1: Standing Financial Instructions

distribution to delegated budgets, including any sums to be held in reserve;

- b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;
- c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and
- d) Regularly update the Board on significant changes to the initial allocations and the application of such funds.

4.2.5 The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Health Board has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Local Health Boards to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context, including population health needs, within which the Health Board will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
 - delivering their well-being objectives, including how the five ways of working have been applied
 - contributing to the seven Well-being Goals,
 - establishing preventative approaches across all care and services

- demonstrate how the Health Board will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
 - demonstrate how the three-year rolling financial breakeven duty is to be achieved.
- 4.3.4 An Integrated Medium Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.
- 4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the LHB's response to delivering the
- NHS Planning Framework,
 - Quality, governance and risk frameworks and plans and
 - Outcomes Framework
- 4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:
- A statement of significant strategies and assumptions on which the plans are based;
 - Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
 - Profiled activity, service, quality, workforce and financial schedules.
 - Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;
- 4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).
- 4.3.8 The Board will:
- a) Approve the Integrated Medium Term Plan prior to the beginning of

Schedule 2.1: Standing Financial Instructions

the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

- b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and
- c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1. Budget Setting

5.1.1 Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

- a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focused on delivery of improved population health, safe patient centred quality services;
- b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;
- c) Take account of approved business cases and associated revenue costs and funding;
- d) Be produced following discussion with appropriate Directors and budget holders;
- e) Be prepared within the limits of available funds;
- f) Take account of ring-fenced, specified and non-recurring allocations and funding;
- g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents)
- h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;
- i) Identify available reserves;
- j) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and
- k) Identify potential risks and opportunities.

5.2. Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Executive Director of Finance, the

management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

- a) The amount of the budget;
- b) The purpose(s) of each budget heading;
- c) Individual or committee responsibilities;
- d) Arrangements during periods of absence;
- e) Authority to exercise virement;
- f) Achievement of planned levels of service; and
- g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

- 5.2.2 The Chief Executive, Executive Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.
- 5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance.
- 5.2.5 All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled and managed appropriately.
- 5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.
- 5.2.7 The Executive Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3. Financial Management, Reporting and Budgetary Control

- 5.3.1 The Executive Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at

Schedule 2.1: Standing Financial Instructions

every Board meeting. Any significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Executive Director of Finance will devise and maintain systems of financial management, performance reporting and budgetary control. These will include:

- a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
 - Understand the current and forecast financial position
 - Evaluate risks and opportunities
 - Use insight to make informed decisions
 - Be consistent with other Board reports, and as a minimum the reports will cover:
 - Current and forecast year end position on statutory financial duties
 - Actual income and expenditure to date compared to budget and showing trends and run rates
 - Forecast year end positions
 - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
 - Explanations of material variances from plan
 - Capital expenditure and projected outturn against plan
 - Investigations and reporting of variances from financial, activity and workforce budgets.
 - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
 - Statement of performance against savings targets
 - Key workforce and other cost drivers
 - Income and expenditure run rates, historic trends, extrapolation and explanations
 - Clear assessment of risks and opportunities
 - Provide a rounded and holistic view of financial and wider organisational performance.
- b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;
- c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

Schedule 2.1: Standing Financial Instructions

- d) Investigation and reporting of variances from financial, activity and workforce budgets;
- e) Monitoring of management action to correct variances;
- f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

- a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;
- b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;
- c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4. Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate

monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

- 5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.
- 5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

- 6.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.
- 6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.
- 6.3 The Director of Finance, on behalf of the LHB, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.
- 6.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.
- 6.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The Director of Corporate Governance will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include
- The Accountability Report containing:
 - o Corporate Governance Report
 - o Remuneration Report and Staff Report
 - o Accountability and Audit Report
 - The Performance Report, which must include:
 - o An overview
 - o A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Executive Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Welsh Ministers. LHBs are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Executive Director of Finance is responsible for:

- a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Health Board business transactions;
- b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;
- c) Establishing separate bank accounts for the LHB's non-exchequer funds;
- d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
- e) Ensuring accounts are not overdrawn except in exceptional and planned situations.
- f) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;
- g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the LHB. No officer other than the Executive Director of Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the LHB and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Executive Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

- a) The conditions under which each bank account is to be operated;
- b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.
- c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.
- d) Authorised signatories are identified with sufficient seniority, and in the case of e-banking approvers, together with an appropriate payment approval hierarchy.
- e) Procedures are in place for prompt banking of money received.
- f) Ensure there are physical security arrangements in place for cheque stationery, e-banking access devices and payment cards.
- g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.
- h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.
- i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Executive Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Executive Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled

Schedule 2.1: Standing Financial Instructions

stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

- 7.4.1 The Executive Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Executive Director of Finance is responsible for:

- a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;
- c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
- d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB;
- e) Ensuring effective control systems are in place for the use of payment cards;
- f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be

undertaken by two officers together, except as may be authorised in writing by the Executive Director of Finance and the coin box keys shall be held by a nominated officer.

- 8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

- 8.2.1 The Executive Director of Finance will issue instructions restricting the use and value of petty cash purchases.
- 8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.
- 8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

- 9.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).
- 9.1.2 The LHB can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The LHB should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

- 9.2.1 The Executive Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.
- 9.2.2 The Executive Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

- 9.3.1 The Executive Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.
- 9.3.2 All officers must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

- 9.4.1 Delegated budget holders and managers are responsible for informing the Executive Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

- 9.4.2 Delegated budget holders and managers must inform the Executive Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made.
- 9.4.3 The Executive Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.
- 9.4.4 Income not received should be dealt with in accordance with losses procedures.
- 9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.
- 9.4.6 The Chief Executive and the Executive Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON-PAY EXPENDITURE

10.1 Scheme of Delegation, Non-Pay Expenditure Limits and Accountability

10.1.1 The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

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; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Executive Director of Finance's responsibilities

10.2.1 The Executive Director of Finance will:

- a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs;
- b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;
- c) Ensure systems are in place for the authorisation of all accounts and claims;
- d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.
- e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.
- f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of

creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

- g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;
- h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

- 10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:
- a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;
 - b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;
 - c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;
 - d) goods have been duly received, examined and are in accordance with specification and order,
 - e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,
 - f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:
 - (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

Schedule 2.1: Standing Financial Instructions

- (ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

- g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive;
- h) All goods, services, or works are ordered on official orders
- i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

10.3.2 The Chief Executive and Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Health Boards must consult with NWSSP Procurement Services, Executive Director of Finance and Director of Corporate Governance prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Health Board Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the LHB, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of [Managing Welsh Public Money](#)
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

- a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- b) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and
- c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NHS Wales Shared Services Partnership (NWSSP) Procurement Services (“**Procurement Services**”).

11.1.2 Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Health Board. Where the term ‘procurement staff’ or ‘department’ is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of Procurement Services, for example ‘Pharmacy’ and ‘Works’ who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised), and the Revised General Consent to enter Individual Contracts [included as Schedule 1 of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB’s Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP’s Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures are:

- kept up to date;
- conform to statutory requirements and regulations;
- adhere to guidance issued by the Welsh Ministers; and
- are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

Schedule 2.1: Standing Financial Instructions

11.3 Legislation Governing Public Procurement

- 11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together **“the 2023 Act”**) and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together **“the PSR Wales Regulations”**) are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services (**“In-Scope Health Services”**) and further detail these can be found in the Welsh Government’s statutory guidance titled “Health service procurement: statutory guidance”. Goods and services which are not In-Scope Health Services (**“Goods and Non-Health Services”**) fall within the scope of the 2023 Act.
- 11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **‘In-Scope Health Services Only’** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words **‘Goods and Non-Health Services Only’** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.
- 11.3.3 **‘Goods and Non-Health Services Only’** The Act governs the procurement of Goods and Non-Health Services. The Welsh Government’s Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the LHBs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the LHB’s SFIs, the former shall prevail.**
- 11.3.4 **‘In Scope Health Services Only’** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure

Schedule 2.1: Standing Financial Instructions

there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the LHB's SFIs, the former shall prevail.**

- 11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.
- 11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.
- 11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:
- Social Partnership and Public Procurement (Wales) Act 2023
 - The Well-being of Future Generations (Wales) Act 2015
 - Welsh Language (Wales) Measure 2011
 - Modern Slavery Act 2015
 - Bribery Act 2010
 - Equality Act 2010
 - Welsh Government's Code of Practice for Ethical Employment in Supply Chains
 - The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
 - Welsh Government 'Towards zero waste: our waste strategy'
 - The Welsh Government Procurement Policy Framework, including:
 - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
 - The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023).

11.4 Procurement Principles and Objectives

- 11.4.1 The term "procurement" embraces the complete process from
-

Schedule 2.1: Standing Financial Instructions

planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **‘Goods and Non-Health Services Only’** The legal and governing principles guiding ‘covered procurement’ under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority’s procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
- Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **‘In Scope Health Services Only’** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the LHB doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government’s Health Service Procurement: Statutory Guidance; and
- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers’ guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out:

- a) requirements for, and exceptions to, formal competitive tendering (**‘Goods and Non-Health Services Only’**);
 - b) tendering processes including post tender discussions;
 - c) requirements and exceptions to obtaining quotations (**‘Goods and Non-**
-

Schedule 2.1: Standing Financial Instructions

Health Services Only’);

- d) evaluation and scoring methodologies; and
- e) approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers’ guidance and the LHB’s delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the LHB to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic and cultural goals in Wales, the Health Board must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 (“**the WBFG Act 2015**”) should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFGA 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The 7 Wellbeing goals are

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

Schedule 2.1: Standing Financial Instructions

11.7.4 The WBFG Act 2015 puts in place a “sustainable development principle” which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- **Collaboration:** acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- **Integration:** considering how the public body’s well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies;
- **Involvement:** the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- **Long term:** the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention:** how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The LHB shall make use of the tools developed by Welsh Government Commercial Delivery Team in implementing the principles of the WBFG Act 2015. The LHB shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, LHBs are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the ‘covered procurement’ objectives in the 2023 Act, Welsh Government’s commitments are set out in Welsh Government’s ‘technical guidance for covered procurement’ and the current and subsequent versions of the Wales Procurement Policy

Schedule 2.1: Standing Financial Instructions

Statement (WPPS). The LHB shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 Health Boards must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and an appropriate representative from the service and other appropriate stakeholders, (depending on the value, risk and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost;
- the likely 'route to market' which will consider the legislative and policy framework set out above;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- equal partners through co-production;
- care for those with the greatest health need first;
- do only what is needed; and
- reduce inappropriate variation.

For '**Goods and Non-Health Services Only**' Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For '**In Scope Health Services Only**' Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the Health Board, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of

Schedule 2.1: Standing Financial Instructions

pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the Health Board should be submitted by Health Board's Director of Corporate Governance to the Audit Committee.

- 11.9.5 The Health Board is required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

- 11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

- 11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Health Board's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies located outside of Wales.
- 11.10.2 **'Goods and Non-Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the 2023 Act and the table below. The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

TABLE 'Goods and Non-Health Services Only'

Goods/Services/Works Whole Life Cost Contract value (figures excl. VAT)	Minimum competition¹	Form of Contract
Below £5,000	Evidence of value for money has been achieved	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
£25,000 plus to the prevailing Procurement Act 2023 threshold ²	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required ³	Formal contract and Purchase Order

¹ subject to the existence of suitable suppliers

² The Procurement Act 2023 – Schedule 1 – threshold amounts

³ in accordance with the requirements set out in Schedule 1.

11.10.3 'In Scope Health Services Only' - In the absence of an existing suitable procurement framework to source the required item, the LHB is required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the health service procurement: statutory guidance. The LHB should note that one of the key objectives of the PSR Wales Regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Schedule 2.1: Standing Financial Instructions

Competition Requirements

11.11 Procurement Thresholds

- 11.11.1 Goods and Non-Health Services Only' The LHB must consider the minimum financial thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in Schedule 1 of the 2023 Act.
- 11.11.2 '**Goods and Non-Health Services Only**' Advice from Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).
- 11.11.3 '**Goods and Non-Health Services Only**' The deliberate subdividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].
- 11.11.4 '**Goods and Non-Health Services Only**' Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000 (excluding VAT), must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.
- 11.11.5 '**In Scope Health Services Only**' There is no minimum financial threshold for application of the PSR Wales Regulations.

11.12 Designing Competitions

- 11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:
- Required timescales are achievable
 - Specifications are drafted which:
 - are fit for inclusion in competition documents;
 - are drafted in a manner encouraging innovation by the market;
 - are capable of being responded to and do not narrow competition;
 - deliver in line with legislative and policy frameworks.
 - include robust performance measures to effectively measure and manage supplier performance; and
 - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities. **‘Goods and Non-Health Services Only’**, under the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI’s) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to ‘light touch regime’ contracts) and in circumstances where the LHB considers that the supplier’s performance under the contract could not appropriately be assessed by reference to key performance indicators (s.52(2) of the 2023 Act)).

11.12.3 **‘Goods and Non-Health Services Only’** Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the “Most Advantageous Tender”, which provides contracting authorities with greater flexibility to take into account wider social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost including (where appropriate) the cost of change and / or end of life costs.

11.12.4 **‘In-Scope Health Services Only’** Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:

- Key Criteria (regulation 6);
- Basic Selection Criteria (regulation 22); and
- Exclusions (regulations 25 and 26).

The LHB is required to ensure the appropriate criteria is set with regards the selected procurement process, as set out under the PSR Wales Regulations and Health service procurement: statutory guidance”.

11.13 Single Quotation Application (SQA) or Single Tender Application (STA) – ‘Goods and Non-Health Services Only’

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- 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.

11.13.2 The appropriate Executive Director must approve all single waivers for their service area prior to submission to Procurement Services. Procurement Services must be consulted prior to any such application being submitted for approval and comments provided on whether the application is supported or not from a procurement perspective (see 11.13.3) prior to the application being submitted for final approval. The Executive Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Executive Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Executive Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;

Schedule 2.1: Standing Financial Instructions

- an acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and
- an “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Health Board has already entered into an arrangement directly. A lack of sufficient time to complete the procurement process is not an acceptable reason for the requesting of an SQA/STA.

11.13.5 As a SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Executive Director of Finance or NWSSP Director of Procurement Services to prevent repeated inappropriate use of a SQA or a STA by the Health Board.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the Health Board to attend Audit Committee;
- escalate to the Board;
- request an internal Audit Review;
- request further training or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. The NWSSP Procurement Manual details the schedule of departures from a SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, Procurement Services will retain a central register of all such activity including SQA/STA's not endorsed by Procurement Services or any exceptional matters.

11.14 Disposals - ‘Goods and Non-Health Services Only’

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed

Schedule 2.1: Standing Financial Instructions

of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 The Health Board must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

- 11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.
- 11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.
- 11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.
- 11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.
- 11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

- 11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:
- retaining accurate records;
 - monitoring contract performance measures;
 - engaging suppliers to ensure performance delivery;
-

Schedule 2.1: Standing Financial Instructions

- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation / delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by Procurement Services.

11.16.3 Advice on Contract Management best practice is available from Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 'Goods and Non-Health Services Only'

- (i) Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.
- (ii) If there is no such provision, the 2023 Act defines such limitations. Further information on contract modifications can be found in sections 74-77 of the 2023 Act and in Guidance: Contract Modifications.

11.17.2 'In-Scope Health Services Only'

- (i) Modification of the scope of an existing contract is possible if:
 - the modification is clearly and unambiguously provided for in the original contract or framework agreement documents, or
 - the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.
- (ii) If provisions set out in 11.17.2 (i) first bullet point are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:
 - solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
 - made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided

Schedule 2.1: Standing Financial Instructions

for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or

- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the Health Board budget holder and the Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.5 This ensures an appropriate identification and assessment of potential risks to the Health Boards compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.6 The budget holder must seek advice from Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods (**'Goods and Non-Health Services Only'**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract frameworks, such as those managed by Welsh Government's Commercial Delivery Team, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the Procurement Services to undertake quotation / tendering exercises (**'Goods and Non-Health Services Only'**) on their behalf in line with SFI 11.11 thresholds (**'Goods and Non-Health Services Only'**).

11.18.3 All orders for goods (**'Goods and Non-Health Services Only'**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Health Board will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

- a) Be consecutively numbered;
- b) State the Health Board's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Health Board by Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Health Board will commission healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. The relevant sections under the Act are as follows:

- Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;
- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Section 32 makes provision in relation to services which can be provided to Health Boards by local authorities;
- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are

in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;

- Part 4 enables Health Boards to make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements with external providers. These reports will be linked to, and consistent with, other Board reports on commissioning and financial performance.

13 GRANT FUNDING

It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the LHBs functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the LHB has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement (Annex 1):

13.2 Policies and procedures

13.2.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Welsh Government's Code of Practice to funding the third sector:

<https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf>

13.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the

Schedule 2.1: Standing Financial Instructions

award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in [Managing Welsh Public Money](#). The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted

- where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, LHBs should ensure principles of good practice available from a number of external sources are considered and reflected in grant programmes.

13.4.1 Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the LHB is responsible for evaluating the programmes to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.

13.4.3 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the LHB to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The LHB must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the LHB should ensure principles of good practice available from a number of external sources are considered and reflected.

13.4.6 The LHB is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

- 14.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.
- 14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.
- 14.1.3 The Board will, after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.
- 14.1.4 The LHB will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.
- 14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

- 14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e., the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)
- 14.2.2 The funded establishment of any department may not be varied without

the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Executive Director of People and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Executive Director of People and Organisational Development is responsible for:

- a) The control framework and detailed procedures which are in place to:
 - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
 - reduce the risk of fraud and error within the payroll function.

- b) Specifying timetables for submission of properly authorised time records and other notifications;
- c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
- d) Agreeing the timing and method of payment with the payroll service;
- e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);
- f) Verification and documentation of data;
- g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- i) Security and confidentiality of payroll information;
- j) Checks to be applied to completed payroll before and after payment; and
- k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

14.5.3 The Chief Executive is responsible for:

- a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;
- b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and
- c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

Schedule 2.1: Standing Financial Instructions

- a) Submitting time records, and other notifications in accordance with agreed timetables;
- b) Completing time records and other notifications in accordance with the Service Level Agreements; and
- c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director of People and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance.

14.6 Contracts of Employment

14.6.1 The Executive Director of People and Organisational Development must:

- a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within Welsh Government capital finance resource limits.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the capital allocations, as set out in the Welsh Government (WG) Capital Resource Limit for the year, and the LHB must not exceed the allocation resource limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043)
<https://gov.wales/nhs-wales-infrastructure-investment-guidance>
- Better business cases: investment decision-making framework
<https://gov.wales/better-business-cases-investment-decision-making-framework>

15.2.2 The Executive Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Health Board's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that formal confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

- a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;
- b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;
- d) Shall ensure that the three year Capital Plan, and detailed annual

Capital Programme, is approved by the Board, as part of the IMTP, prior to the commencement of the financial year;

- e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and
- f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

- a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;
- b) That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme by the Health Board shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

- a) Specific authority to commit expenditure;
- b) Authority to proceed to tender; and
- c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.4.7 The Director of Planning and Executive Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall

Schedule 2.1: Standing Financial Instructions

fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Executive Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Executive Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Executive Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Executive Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

- a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
- c) Lease agreements in respect of assets held under a finance lease

Schedule 2.1: Standing Financial Instructions

and included on the LHB's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Executive Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance. This procedure shall make provision for:

- a) Recording managerial responsibility for each asset;
- b) Identification of additions and disposals;
- c) Identification of all repairs and maintenance expenses;
- d) Physical security of assets;
- e) Regular verification of the existence of, condition of, and title to, assets recorded;
- f) Identification and reporting of all costs associated with the retention of an asset; and
- g) Reporting, recording and safekeeping of cash, cheques, and

Schedule 2.1: Standing Financial Instructions

negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Executive Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as LHB property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- a) Kept to a minimum;
- b) Subjected to annual stock take; and
- c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Executive Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Executive Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements for receipt, issues, and returns of goods to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Executive Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Executive Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Executive Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals)

Schedule 2.1: Standing Financial Instructions

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

- 16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance or authorised officer who shall satisfy themselves that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Executive Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LHB asset and goods, the head of department or authorised deputy will determine and advise the Executive Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

- a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Executive Director of Finance;
- b) Recorded by the Condemning Officer in a form approved by the Executive Director of Finance which will indicate whether the assets and goods are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Executive Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Executive Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

- 17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Executive Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and/or the Chief Executive.
- 17.2.4 Where a criminal offence is suspected, the Executive Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.
- 17.2.5 The Executive Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.
- 17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance must notify:
- a) The Audit Committee on behalf of the Board, and
 - b) An Auditor General's representative.
- 17.2.7 The Executive Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.
- 17.2.8 The Executive Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).
- 17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.
- 17.2.10 For any loss or special payments, the Executive Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

Schedule 2.1: Standing Financial Instructions

- 17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.
- 17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.
- 17.2.13 The Executive Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.
- 17.2.14 The LHB must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the LHB digital systems and data and shall:

- a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the LHB's digital systems and data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;
- b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information System Regulations 2018 are being carried out;

- d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information System Regulations 2018; and
- e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Executive Director of Finance

18.3.1 The Executive Director of Finance shall need to ensure that new financial data and systems, and amendments to current financial data and systems, are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the LHB arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 LHB Responsibility

- 19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.
- 19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Executive Director of Finance.
- 19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

- 19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:
- a) Notices and information booklets;
 - b) Hospital admission documentation and property records; and
 - c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Executive Director of Finance

- 19.3.1 The Executive Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

- 20.1.1 Paragraph (x) of Section A to the SOs refers to the LHB having specified powers to act as corporate trustee for the management of funds it holds on trust (charitable funds). SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.
- 20.1.2 The discharge of the LHB's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.
- 20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

- 20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.
- 20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.
- 20.2.3 The LHB shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

- 20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.
- 20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as “General Consent to enter individual contracts” replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI’s) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

“(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

- (a) acquire and dispose of property,*
- (b) enter into contracts,*
- (c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).*

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case).”

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 (**“the Investment Guidance”**) includes the following in relation to Local Health Boards:

“Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.”

Schedule 2.1: Standing Financial Instructions

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

“Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.”

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process).

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;
- All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

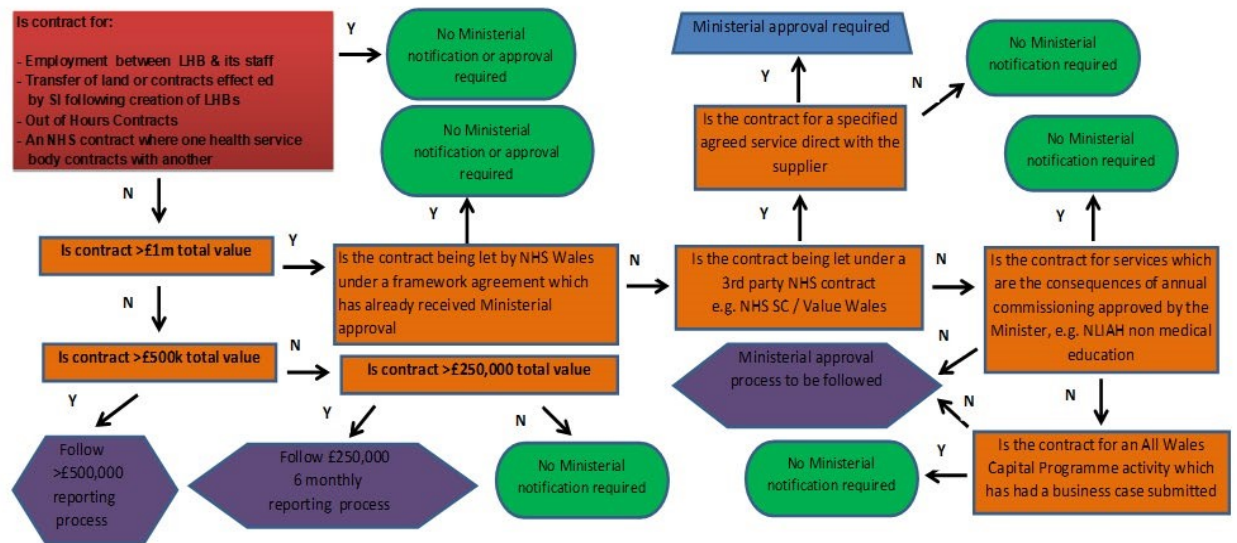
The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

- i. Contracts of employment between LHBs, HEIW, or DHCW and their staff;

Schedule 2.1: Standing Financial Instructions

- ii. Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW
 - iii. Out of hours contracts;
 - iv. All NHS contracts; that is where one health services body contracts with another health service body;
 - v. Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g., annual education and training commissioning also do not require further Ministerial notification or consent; and
 - vi. Contracts between £500k - £1 million (for noting) and £1 million + (for approval).
- a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.
- b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team:
Robert.Eveleigh@gov.wales



Schedule 2.1: Standing Financial Instructions

Audit Committee

Adroddiad Cydymffurfiaeth: Chwarter 3 2025-26

Conformance Report: Quarter 3 2025-26

Dyddiad y Cyfarfod Date of Meeting	17 February 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Denise Roberts, Head of Capital, Business Improvement and Compliance
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 Noting & For Approval

Crynodeb Gweithredol

Executive Summary

This Conformance Report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations.

The areas covered in this report are:

- **Purchase orders that are non-compliant with SFI's (October – December 2025)**

This data set relates to orders being raised after the invoice has been received.

Non-compliance for the period is 234 in October, 254 in November and 220 in December 2025. The total 708 breaches during Quarter 3 (Q3) is an improvement compared to 795 in Q3 2024-25. A significant proportion of the orders are for known expenditure such as utilities charges, contractual clinical services and computer licence fees, however, the variable nature of the volume means that retrospective orders are produced.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure.

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

During Quarter 3, the number of file notes approved was 20 with a total contract value of £2.3m. The main breach is a Radiology contract to the value of £1.5m.

- **Single Waivers (October – December 2025)**

The number of waivers issued year to date has significantly decreased compared to this period last year.

Single Tenders – 7 approved in Q3, compared to 11 last year.

Single Quote – 8 approved in Q3, compared to 0 last year.

- **Receivables and conformance with payroll procedures**

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

As at 31st December 2025, there were 3,042 outstanding invoices, totalling £8.8m, of which 510 invoices, totalling £3.3m were less than 30 days old.

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

Staff Overpayment

For the period October to December 2025 there were 116 staff overpayments, with a gross value of £0.276m, comparable to 114 and £0.295m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (101 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 31st December 2025 the balance outstanding was £1.0m, compared to £1.1m at 31st December 2024.

Enhanced Establishment Control

An Enhanced Establishment Control Panel has been introduced to scrutinise Establishment Control Requests. The Executive Panel meet on a weekly basis to objectively review requests on an individual basis against agreed indicators.

A breach can occur if an individual is working to contract terms that have not been approved through the Establishment Control Process. During Quarter 3, 1 breach has been noted.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 97%.

- **Losses and special payments**

Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

Clinical negligence claims are managed by Legal and Risk Services and there were 354 active claims at the end of December 2025. Of these 200 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £246m (before reimbursement from the Welsh Risk Pool).

- **Welsh Risk Pool Penalties – Learning from Events Report**

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

As at 31st December 2025 the number of claims outstanding is 12. This is a decrease of 5 in the quarter.

- **Contract Procurement Review Update**

Contract Register – Development to create a pan-BCU document and records management system for contracts is progressing. The external software solutions company has produced and issued a first draft of a contract register for the Health Board to test and feedback in January 2026. It is currently anticipated that the register will ‘go live’ in March 2026.

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

Appendix 1: Conformance Report – Quarter 3 (October to December 2025).

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

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

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

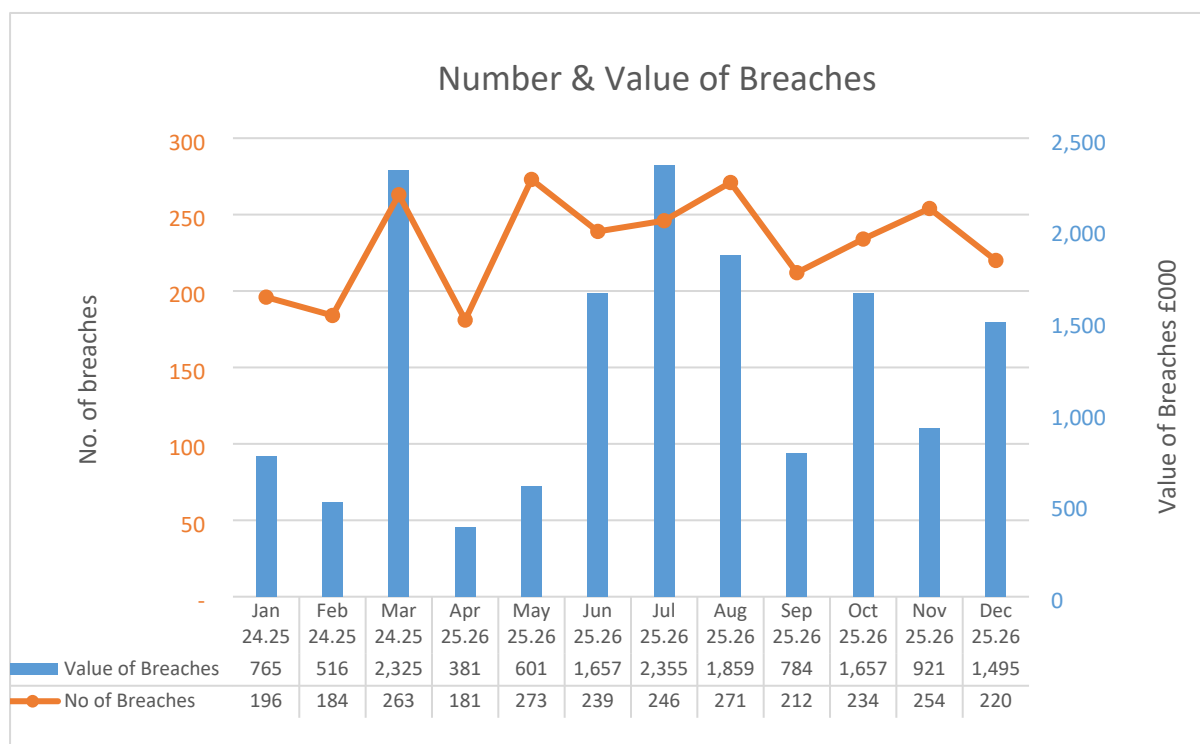
*Exemptions apply (see SFIs)

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

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a 17% decrease in the value of Purchase Order breaches in quarter 3 (Q3), with 708 breaches reported to the value of £4.0m. During the same period last Financial Year, the number of breaches were 795 with a value of £4.6m.

The value and number of breaches between January and December 2025 are detailed below:



The quarterly value of breaches by category are detailed below:

Expenditure Type	2024-25				2025-26		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Pay (Agency, Fees etc)	494,397	279,110	307,865	393,806	233,105	329,659	264,175
Managed Practices	129,987	136,041	115,372	42,796	39,166	179,627	111,163
Non-Pay	2,307,822	3,896,810	4,134,814	3,179,579	2,365,783	4,488,975	3,697,706
Total	2,932,206	4,311,961	4,558,051	3,606,181	2,638,054	4,998,261	4,073,044

Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q3 are as follows:

Division	Month of Breach	Item Description	PO Amount £000's
Regional Services	Dec-25	PROVISION OF CT AND MRI SERVICE FOR BOTH CORE AND ADDITIONAL ACTIVITY	803
Health Community East	Dec-25	ADASTRA INV240568	268
Utilities and Rates	Oct-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL - 01-31/08/2025	251
Utilities and Rates	Oct-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL - 01-30/09/25	239
Utilities and Rates	Oct-25	ELECTRIC CHARGES FOR WREXHAM MAELOR HOSPITAL - 01-31/08/2025	210

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

Division	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Centre	54	43	80	45	76	101	92	112	122	71	114	53	786
East	68	57	66	77	87	67	68	72	77	75	88	70	681
West	37	47	68	53	59	57	60	80	37	43	54	38	481
Regional Services	34	18	36	10	35	21	20	49	20	20	25	20	220
Chief Digital Information Officer	5	14	28	7	30	6	38	24	20	1	37	19	182

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list has now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

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

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

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

During Quarter 3, the number of file notes approved was 20 with a total contract value of £2.3m. The table below provides detail for each file note:

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	DEPARTMENT	CONTRACT PERIOD	TOTAL CONTRACT VALUE
2526-077-FN-BCU	UNIVERSITY SOUTHAMPTON HOSPITAL NHS TRUST	MY MEDICAL RECORD SOLUTION	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	CANCER SERVICES	12 MONTHS	£24,303.33
2526-084-FN-BCU	PRESCQIPP CIC	PRESQIPP CIC COMPUTER SYSTEM FOR ONE YEAR 25-26	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MEDICINE MANAGEMENT	ONE OFF	£17,644.00
2526-148-FN-BCU	CYMEN CYF	TRANSLATION SERVICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	WELSH LANGUAGE SERVICE	ONE OFF	£30,271.43
2526-149-FN-BCU	PRYSG TRANSLATION	TRANSLATION SERVICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	WELSH LANGUAGE SERVICE	12 MONTHS	£28,467.60
2526-160-FN-BCU	THE RENAL ASSOCIATION	UK KIDNEY ASSOCIATION DATA PROCESSING 25 JAN - DEC	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	RENAL	ONE OFF	£8,036.39
2526-161-FN-BCU	SECURITAS	PAYMENTS FOR PAGER REPAIRS	OTHER (PAYMENTS OUTSIDE OF AGREED CONTRACT)	IT	12 MONTHS	£6,295.00
2526-170-FN-BCU	QLIKTECH UK LTD	QILKVIEW MAINTENANCE ENTERPRISE RENEWAL	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	FINANCE	ONE OFF	£12,158.44
2526-171-FN-BCU	KINGS FUND	CLINICAL LEADERS PROGRAMME	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PATHOLOGY	ONE OFF	£7,350.00
2526-173-FN-BCU	THE NATIONAL EXAMINATION BOARD IN OCCUPATIONAL SAFETY AND HEALTH	ACCREDITATION OF IN-HOUSE COURSES AND AWARDS OF CERTIFICATION TOGETHER WITH COURSE MATERIALS AND SUPPORT	OTHER (E WAIVER SIGNED OFF FOR £25K, EXTRA REQUISITION TAKES IT OVER THRESHOLD)	WORKFORCE AND DEVELOPMENT	12 MONTHS	£11,600.00
2526-175-FN-BCU	WORKINCONFIDENCE LTD	WORK IN CONFIDENCE PLATFORM - 1 YEAR SUBSCRIPTION	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PEOPLE SERVICES	ONE OFF	£21,891.00
2526-176-FN-BCU	RADIOLOGY MANAGEMENT SOLUTIONS LTD	STAFFING FOR THE MODULAR CT SCANNER AT YSBYTY GLAN CLWYD AND THE MODULAR MRI SCANNERS AT WREXHAM MAELOR AND YSBYTY GLAN CLWYD AND ULTRASOUND SCANNING	OTHER (FILE NOTE TO COVER INVOICES UNTIL TENDER HAS BEEN AWARDED)	RADIOLOGY	ONE OFF	£1,500,000.00

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	DEPARTMENT	CONTRACT PERIOD	TOTAL CONTRACT VALUE
2526-177-FN-BCU	SCAN ASSURE MEDICAL ULTRASOUND LTD	NON-OBSTETRIC, OBSTETRIC AND ANOMALY ULTRASOUND SCANNING AT ALL THREE ACUTE HOSPITAL SITES	OTHER (FILE NOTE TO COVER INVOICES UNTIL TENDER HAS BEEN AWARDED)	RADIOLOGY	ONE OFF	£232,000.00
2526-179-FN-BCU	ROYAL MAIL GROUP PLC	PAYMENT OF COLLECTION INVOICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	FACILITIES	ONE OFF	£250,000.00
2526-180-FN-BCU	HUMAN TISSUE AUTHORITY	INVOICE FOR HTA FEE FOR LICENCES UNDER SECTION 16(2) HUMAN TISSUE - MAKING OF POSTMORTEM, REMOVAL AND STORAGE - LICENCE NO: 12153 - INVOICE NUMBER: P10417	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PATHOLOGY	ONE OFF	£13,450.00
2526-189-FN-BCU	EGTON MEDICAL INFORMATION SYSTEMS LTD (EMIS HEALTH)	OPTUM CS100 SOFTWARE SERVICE RENEWAL 1/9/25 - 31/8/26	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MENTAL HEALTH	ONE OFF	£40,909.05
2526-199-FN-BCU	UNIVERSITY OF MANCHESTER	MSC CLINICAL IMMUNOLOGY 2ND YEAR	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PATHOLOGY	ONE OFF	£6,500.00
2526-206-FN-BCU	CARDIFF UNIVERSITY	3X PG CERT MEDICAL EDUCATION COURSES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MEDICAL EDUCATION	ONE OFF	£17,700.00
2526-208-FN-BCU	ROTAMAP LTD	ROTAMAP CLW ONLINE ROTA MANAGEMENT SERVICE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	GENERAL SURGERY	ONE OFF	£21,462.59
2526-212-FN-BCU	RHIANFA LTD	B&B FOR VISITING FACULTY TEACHING ON THE EUROPEAN TRAUMA LIFE SUPPORT COURSE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	RESUS	ONE OFF	£8,350.90
2526-225-FN-BCU	CENTAUR TRAINING AND DEVELOPMENT LTD	LOAD MANAGEMENT TRAINING	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	WORKFORCE AND DEVELOPMENT	ONE OFF	£5,442.00

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

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

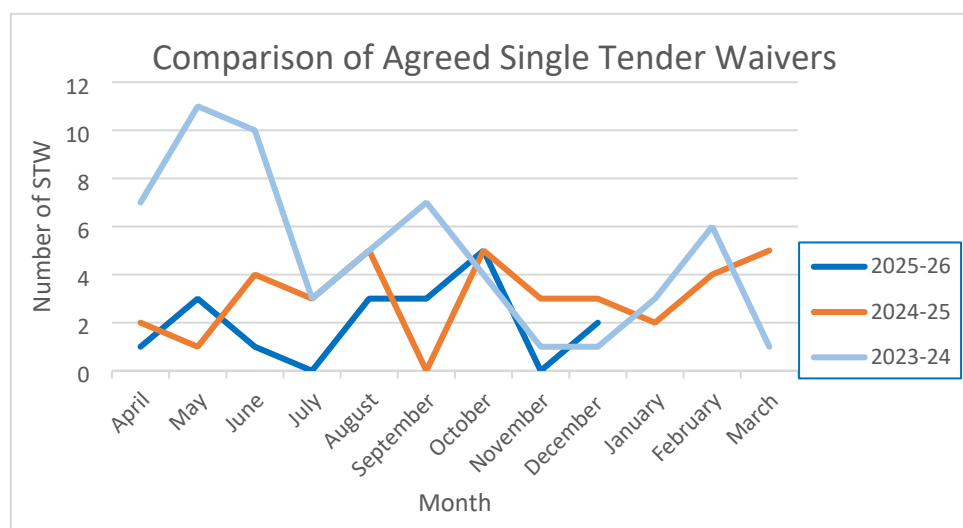
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g., specific equipment required, or compliance with a warranty cover clause;
- A need to retain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

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

Single Tender Waiver	2024-25 Q3	2024-25 FYE	2025-26 Q3	2025-26 FYE
Waivers Issued	11	44	10	34
Waivers Approved	11	37	7	18
Value of Approved Waivers	£1.8m	£4.6m	£0.6m	£2.3m
Waivers approval above EU Threshold	1	3	2	4
Cancelled Waivers	3	8	2	5

The number and value of approved waivers have decreased in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 2**.



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

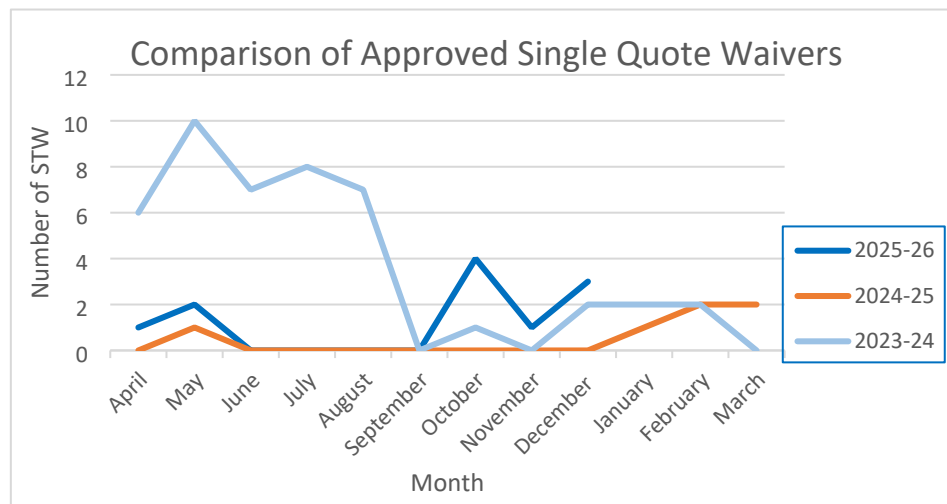
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

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

Single Quote Waiver	2024-25 Q3	2024-25 FYE	2025-26 Q3	2025-26 FYE
Waivers Issued	13	60	12	31
Waivers Approved	0	6	8	11
Value of Approved Waivers	£0.0m	£0.07m	£0.1m	£0.1m
Cancelled Waivers	0	0	0	2

The number of approved waivers has increased compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 3**.



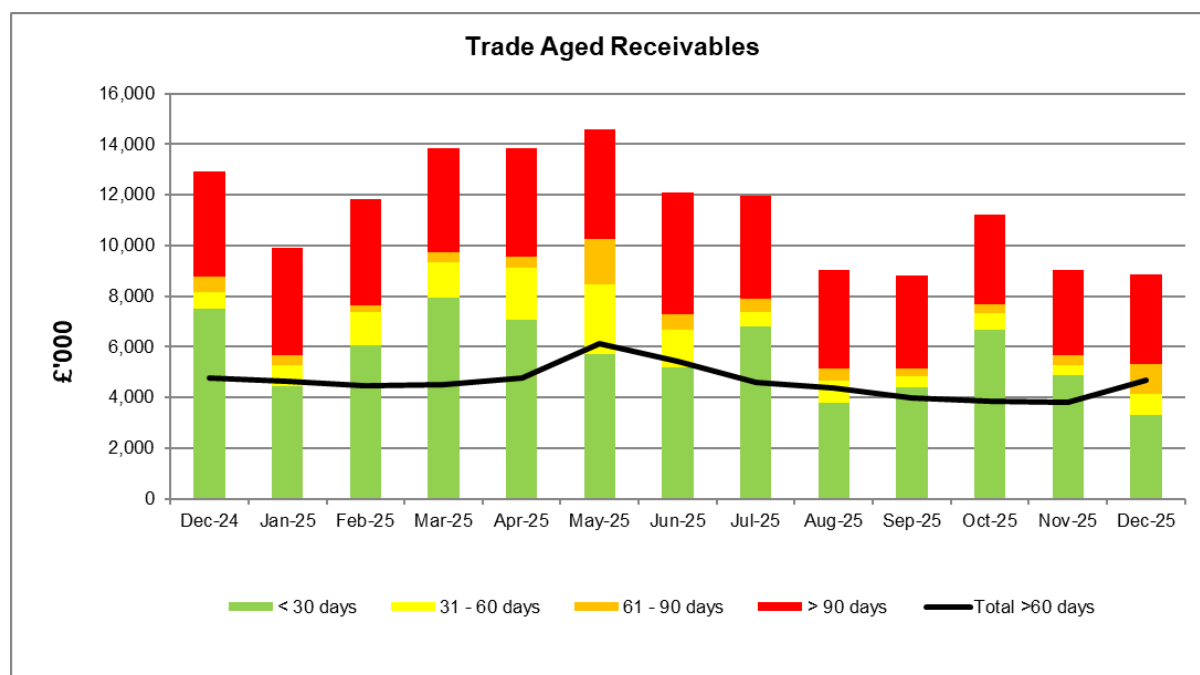
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

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

As at 31st December 2025, there were 3,042 outstanding invoices, totalling £8.8m, of which 510 invoices, totalling £3.3m were less than 30 days old.

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



Provisions for bad and doubtful debts

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

Receivable balances over £10,000 and in excess of 6 months old as at 31 December 2025

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

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
NHS Cheshire and Merseyside ICB	175	8	Charges were queried by the debtor. BCU Income Team has responded with evidence to support the detail.	Oct 23 to Apr 25
NHS Shropshire Telford and Wrekin ICB	11	1	Invoice paid January 2026.	Oct-24
The Walton Centre	74	3	All queries have been responded to by the Income Team. One item is subject to a partial credit note pending internal review. Remittance has been received from the debtor to confirm payment for the remaining 2 invoices outstanding.	Apr 22 - Sep 23
Non-NHS Company	37	1	Accounts Receivable Team continue to chase. No response received from company. Invoice will be referred to CCI.	Feb-25
Amlwch Health Centre	10	1	Monthly instalment plan agreed.	Apr-14
Overseas Patient	14	1	Chasing action ongoing following confirmation from the Home Office that the debt remains payable.	Jul-24
Overseas Patient	20	1	Debt has been referred to CCI, who have instructed International Credit Exchange (ICE).	Aug-22
Overseas Patient	28	1	Debt has been referred to CCI, who have instructed International Credit Exchange (ICE).	Sep-22
Overseas Patient	10	1	Instalment plan agreed and accepted, August 25.	Jun-25
Private Patient	10	1	Invoice raised for charge for inpatient treatment has been referred to the patient's insurance company. Accounts Receivable are working with the insurer to obtain payment, contractual restraints preventing referral to CCI are being investigated.	Oct-20
Salary Overpayment	10	1	Instalment plan agreed and accepted November 25.	Feb-24
Salary Overpayment	16	1	Discussions ongoing between BCU Senior Workforce colleagues. Awaiting further information from the employee and advice from Workforce.	Feb-22
Salary Overpayment	17	1	Instalment plan agreed and accepted, January 2026.	Dec-24
Salary Overpayment	11	1	Debt collection activity is ongoing. Escalated chasing efforts have commenced due to lack of response from the debtor.	Mar-25
Salary Overpayment	26	1	Overpayment is awaiting corrective action by the Clinical Service and has been escalated for further action.	Jul-23
Salary Overpayment	28	1	Senior management team in discussions with the debtor to agree a suitable repayment plan. An underpayment has been offset against the original outstanding balance.	Dec-23
Salary Overpayment	10	1	Debt has been referred to CCI. Repayment plan in place since October 2025.	Sep-24
Salary Overpayment	11	1	Instalment plan agreed and accepted.	Feb-25
Salary Overpayment	10	1	Debt has been referred to CCI. Repayment plan in place since April 2023.	Nov-21

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
Q3 Total	528	28		
Q2 Total	1,464	54		
Q1 Total	1,583	49		
Movement in current quarter	936	26		

- *St David's Hospice - Agreed repayment plan over a 3-year period*

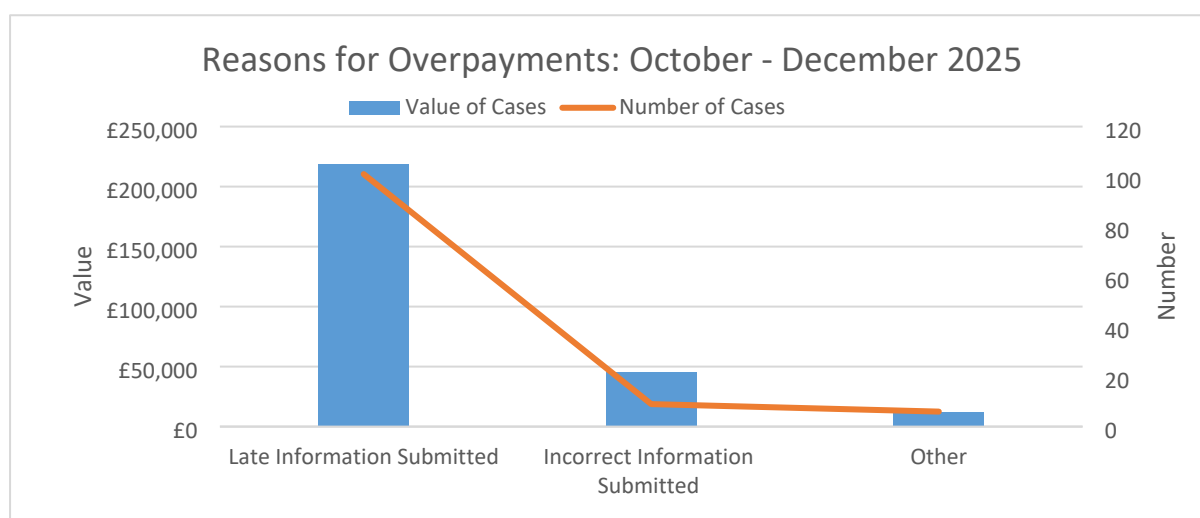
b) Staff Overpayments

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

	2024-25 Q3	2024-25 PYE	2025-26 Q3	2025-26 FYE
Number of Salary Overpayments	114	387	116	357
Value of Salary Overpayments	£0.295m	£0.916m	£0.276m	£0.785m

For the period October to December 2025 there were 116 staff overpayments, with a gross value of £0.276m, comparable to 114 and £0.295m in the previous Financial Year.

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



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

The specific actions undertaken by the team are:

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

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

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

Staff Overpayment Repayments

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

As at 31st December 2025 the balance outstanding was £0.969m (31st December 2024 £1.117m).

The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	340	55%	£0.413m
Collection Agents	117	19%	£0.217m
In Dispute or Under Review	86	14%	£0.243m
Reminder Stage	55	9%	£0.070m
Invoice Stage	20	3%	£0.026m

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

The extremely aged debts are there because either:

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

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

Establishment Control Breaches

An Enhanced Establishment Control Panel has been introduced to scrutinise Establishment Control Requests. The Executive Panel meet on a weekly basis to objectively review requests on an individual basis against agreed indicators.

The Panel will support the re-shaping of the organisation towards sustainability through skill mix and enabling changes to current structures where appropriate.

A breach can occur if an individual is working to contract terms that have not been approved through the Establishment Control Process. During Quarter 3, 1 breach has been noted.

Section 3 - Conformance with Losses and Special Payments Procedures

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

The losses and special payments table below provides an overview of the losses incurred to December 2025. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years, and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 354 active claims at the end of December 2025. Of these 200 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £246m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

44% of the caseload (154 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2025/26	74
2024/25	75
2023/24	60
2022/23	46
2021/22	29
2020/21	30
2019/20	23
2018/19	9
2017/18	0
2016/17	2
2015/16	1
2014/15	1
2013/14	0
2011/12	1
2010/11	1
2009/10	1
2008/09	1
Total claims	354

Losses and Special Payments

	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Latest quarter analysis and further action
	£	£	£	£	
Medical Negligence					
Gross cost	6,497,793	6,104,839	7,964,638	4,415,789	Payments were made on 158 cases, of which 11 came under the Redress Scheme.
WRPS Reclaim	-5,764,116	-5,280,925	-7,228,209	-3,516,837	
Net Cost	733,677	823,914	736,429	898,952	
Personal Injury					
Gross cost	80,174	297,831	64,059	250,999	Payments were made on 50 cases.
WRPS Reclaim	0	-209,528	-36,000	-148,243	
Net cost	80,174	88,303	28,059	102,756	
Loss of cash	0	0	0	1,185	There were 5 claims for lost cash in Q4, claims have been referred to the police and counter fraud where necessary.
Debtors written off	107,146	0	18	170,575	A data cleanse of outstanding invoices is being undertaken and a number of aged debts are being written off where all debt collection efforts have been exhausted, or the debt has met the statutory regulation.
Loss or damage to equipment, property and stock	98,152	87,841	59,265	383,012	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. A correcting entry in Q3 has been entered due to the recoding of write offs in the pharmacy system (back dated to 1/4/25)
Ex-gratia payments	12,907	50,541	71,095	7,640	Relates to 14 payments for loss/damage of patient's property, 11 employment tribunal and 1 ombudsman payments for delayed and unsatisfactory treatment and 1 payment for reimbursement of private appointment fees.
VERS Payments	0	0	0	0	All payments are approved by the Remuneration Committee.
Total	1,032,056	1,050,599	894,866	1,564,120	

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

Section 4 – Welsh Risk Pool Penalties – Learning from Events Report

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP).

WRP can levy a penalty for late submissions, which is recharged to divisions where the LFER or supporting evidence is late. At present, the penalty is £2,500 per late submission (which can recur). 23 penalties have been applied this year to date costing the Health Board £57,500. The total number of penalties during 2024-25 was 66 at a cost to the Health Board of £165,000.

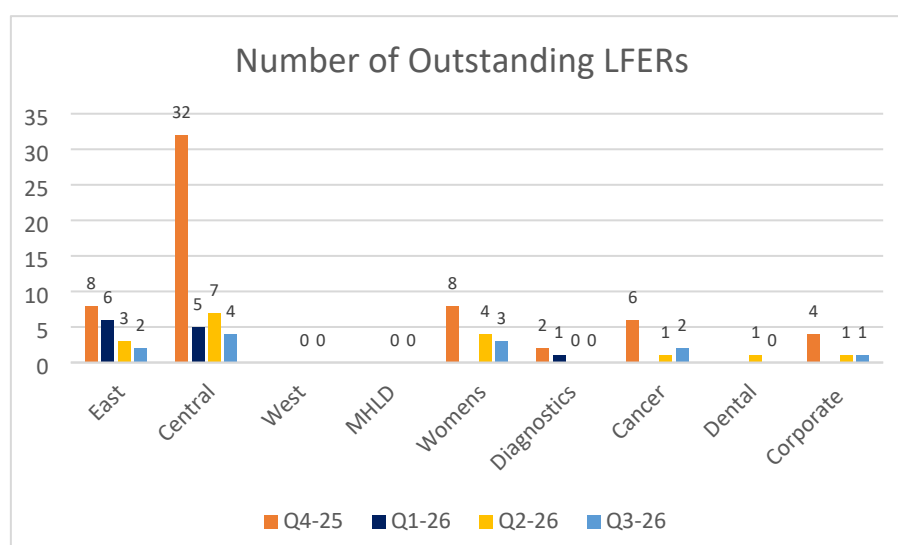
The Health Board has implemented a clear process, and data is provided to divisions on a weekly basis to support local performance management and recovery of overdue submissions in real time. A bi-weekly meeting is held to support and scrutinise the division's performance. All divisions have now embedded LFER monitoring into their governance structures.

At 31 December 2025 the total number of outstanding LFERs was 12 (30th September 2025, 17).

The overdue LFERs, by category and division, are detailed below: The overdue LFERs, by category and division, are detailed below:

IHC/Division	Claims	Claims Deferred	Redress	Redress Deferred	Total
East	0	2	0	0	2
Central	2	2	0	0	4
West	0	0	0	0	0
MHLD	0	0	0	0	0
Womens	1	2	0	0	3
Diagnostics	0	0	0	0	0
Cancer	1	1	0	0	2
Dental	0	0	0	0	0
Estates	0	1	0	0	1
Total	4	8	0	0	12

The chart below provides a summary of the outstanding LFER's per quarter:



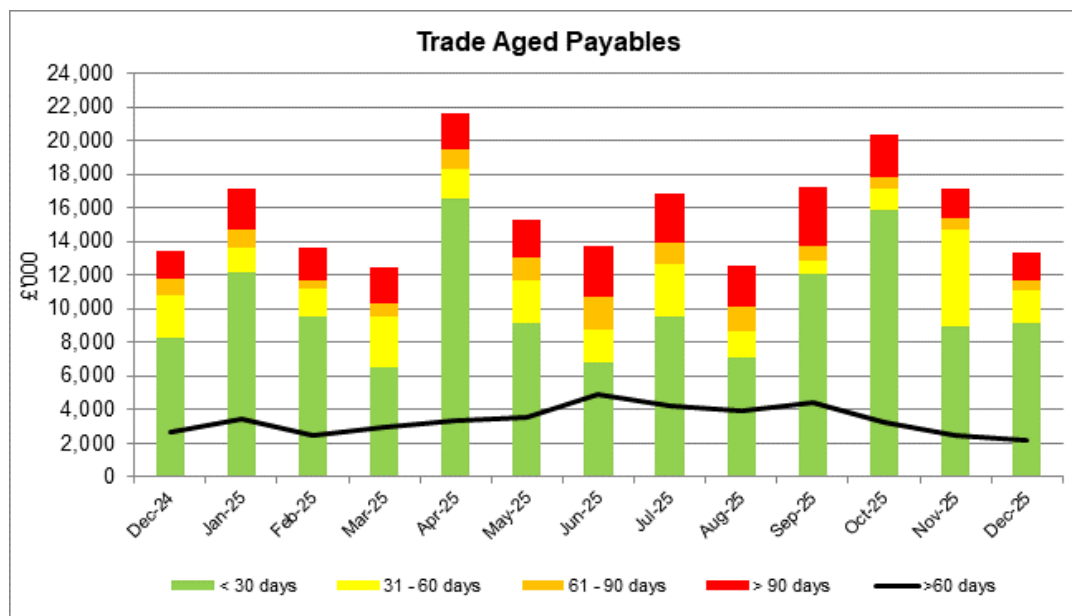
Section 5 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 97%.

High Value (£10,000 plus) Exceptions

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



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

Payable balances over 6 months old and over £10,000 as at 31st December 2025

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Flintshire County Council	156	4	Awaiting PO numbers & correction to PO raised without VAT	Jan, Feb, Apr and Jun 25
Gwynedd Council	146	1	Awaiting approval and signature on contract before the PO can be receipted	Jun 25
Denbighshire County Council	70	2	Awaiting receipt of PO & queried VAT charge on invoice with supplier	Apr & Jun 25
Medtronic Ltd	45	3	Duplicate invoices, supplier has been contacted requesting credits	Mar 23, Feb & Dec 24
AHLC Solutions Ltd	38	1	Interest Claimed by Supplier in line with the Late Payments of Commercial Debts (Interest) Act 1998	Jun 25
Treherne Care and Consultancy Ltd	37	2	Invoices disputed, costs not agreed before billed, department are investigating	Sept & Oct 24
East Lancashire Hospitals NHS Trust	31	1	PO receipting/matching issue, email to Accounts Payable to resolve	Mar 25
Abbott Medical UK Ltd	15	1	Invoice received by Accounts Payable in December 2025. Invoice is awaiting receipt of PO	Nov 24
Becton Dickson UK Ltd	12	1	Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice	Sep 22
Liaison Financial Services Ltd	10	1	Full credit has been received, awaiting AP to match and clear	Oct 24
SG Fleet Solutions UK Ltd	10	1	Invoice is validated and awaiting payment but as the supplier account is in credit the invoice can't be paid	Mar 25
Stryker Uk Ltd	10	1	Awaiting credit from supplier	Nov 24

Appendix 2 - Approved Single Tender Waivers >£25K between 1st October – 31st December 2025

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
2025/2026-1582	17/12/2025	Corporate	Primary Care Commissioning CIC	Preparation of a Pharmaceutical Needs Assessment (see attachment)	Follow on from previous waiver	£39,000.00	Accept	Procurement Support the following as the project is an All Wales initiative to undertake and develop Pharmaceutical Needs Assessment.	No
2025/2026-1587	17/12/2025	Mental Health & LD	Ascom	Ascom personal security alarm system	Genuinely one provider	£31,905.31	Accept	Procurement supports this waiver on the basis of sole supplier. As the system is closed protocol no other third party can access to maintain or repair. Continuation of previous waivers.	No
2025/2026-1598	15/10/2025	Capital	Amercare	Purchase of 2 x negative pressure pharmaceutical isolators (as per attached quote, ref: AME10054 Rev 02)	Compatibility Issue (eg. warranty cover clause or specific equipment)	£96,274.00	Accept	Procurement supports this waiver request for the following reasons: • The current isolators on site are already Amercare devices. Amercare are therefore the preferred supplier for standardisation purposes and for compatibility with existing equipment and ducting. • The existing Amercare isolators were installed as part of a wider capital works project. • Replacing on a like for like basis mitigates any additional cost and service disruption of enabling works. • Amercare are not listed on any pharmaceutical isolator purchasing frameworks, therefore a direct award via framework is not possible on this occasion.	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
2025/2026-1602	23/10/2025	Estates and Facilities	Honeywell	Single supplier waiver to Honeywell Systems for an annual maintenance (and agreed support) contract on Primary Care sites for Building Management Systems that are designed, manufactured and installed and commissioned by Honeywell for the period 1st April 2025 to 31st March 2028 (i.e. 3 years) The hardware and software used on these systems is closed protocol so the work cannot be outsourced to other suppliers	Genuinely one provider	£175,188.29	Accept	Procurement supports this waiver on the basis of sole supplier. Whilst Honeywell do offer access to some of their systems to sub-contractors, we have confirmed with them that this specific system is closed protocol, and no other contractor can work on it. Essential maintenance work.	Yes
2025/2026-1603	23/10/2025	Estates and Facilities	Honeywell	The Building Management System that supports the BCUHB West division is a Honeywell EBI (Enterprise Building Integrator) which links Ysbyty Gwynedd Hospital with all of our remote community hospitals. Within each of our hospitals the existing BMS controllers are to be upgraded to Honeywell CPO's. These controllers are open protocol and can communicate with other system protocols, such as BACNET, MODBUS etc. However, CPO (Comfort Point Open TM) does not have a partnership program and is not available to other system integrators -	Genuinely one provider	£150,000.00	Accept	Procurement supports this waiver on the basis of sole supplier. Whilst Honeywell do offer access to some of their systems to sub-contractors, we have confirmed with them that this specific system is closed protocol, and no other contractor can work on it.	Yes

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
				Therefore the upgrades can only be carried out by Honeywell Building Solutions - Procurement is aware of the situation and satisfied that a STW can be used for this procurement.					
2025/2026-1604	28/10/2025	Secondary Care - Managed Clinical Support	Stryker UK Ltd	12-month Maintenance contract for Stryker drills in Orthopaedics/Theatres Wrexham & Glan Clwyd /Abergele. Stryker are the OEM with access to parts; no other supplier can maintain them.	Maintenance	£74,875.34	Accept	Procurement Services accept this waiver request based on the Original Engineering Manufacturer (OEM) nature of the required maintenance. It has been clearly noted through discussion with the relevant department that Stryker UK Ltd should be deemed the Sole Supplier who can maintain the equipment in line with manufacturer guidelines. No other supplier has access to the necessary parts required to maintain this equipment as per the requirement. This contract will ensure that key theatre equipment is maintained to the required standard, further supporting patient safety and NHS waiting lists. Non-approval will directly impact theatre procedures due to equipment not being maintained as required, providing increased risk to patient safety. It should be noted that NWSSP Procurement have worked closely with the department and supplier to align multiple contracts across the Health Board to consolidate spend and mitigate potential contract management issues. Joe Angell 17/10/2025 Samuel Hughes 17/10/2025	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
2025/2026-1605	28/10/2025	IHC Centre (Area Team - Central)	Design Specific	x2 Bariatric Bench Seats	Genuinely one provider	£53,400.00	Accept	Procurement supports this waiver as there are only 2 suppliers of these chair tippers on the market – Diaco and Design Specific. The Diaco chairs are not compliant with Dental's specification requirements. Design Specific are offering a discount against this purchase for the trade in of the old equipment (£8000 in total). Design Specific are the preferred supplier on this occasion due to both the product specification meeting Dental's compliance standards, and also the part-exchange discount offers for trade in of the existing obsolete equipment being replaced. Design Specific are not listed on any frameworks, therefore a direct award via framework is not possible on this occasion.	No

Appendix 3 - Approved Single Quote Waivers >£25K between 1st October – 31st December 2025

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
2025/2026-1583	28/10/2025	Estates and Facilities	Solutions from HSE	Training Course Provider	The Health Board has faced significant scrutiny from the Health and Safety Executive, and this continues. A training need to upskill Health and Safety Team members has been identified and the most appropriate provider for this training is the HSE as the enforcer. This ensures the team are being trained to the standards organisations are expected to achieve by the HSE.	£16,800.00	Accept	HSE training is necessary for the Health Board to comply with Health and Safety Regulations. HSE are the Governments Health and Safety Regulator and set the standards for H&S. Should the Health Board go with a different supplier they might not adhere to the standards that are currently set by HSE or there may be inconsistencies that don't address the issues raised by HSE. No procurement exercise has been undertaken.
2025/2026-1584	06/10/2025	Corporate	CILEX	CILEX Registration fees	Genuinely one provider	£15,121.00	Accept	CILEX- Chartered Institute of Legal Executives is the only professional body and is the regulator for Legal Professionals here in Wales. Procurement supports this waiver- Gethin Barlow
2025/2026-1597	15/10/2025	Corporate	Better	The ePMA system is delivered by Better Care. A Sandbox has been approved by the Board to support the delivery of the training for a period up to 31st March 2026. Procurement have confirmed there is no other route to market. This remains within the financial envelope of this financial year. The approval paper ePMA - SBAR Request for Sandbox v1.4	Genuinely one provider	£7,200.00	Accept	Procurement supports this waiver on the basis that no other provider can fulfil this requirement as it is directly linked to the EPMA system with is provided by Better.

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
2025/2026-1599	19/12/2025	Corporate	University of Bradford	Dementia Care Mapping Training which the University of Bradford hold the licence for. Discussed with Procurement. Funded by charitable funds. Copy emails attached	Genuinely one provider	£18,000.00	Accept	Procurement supports this waiver. Approval is sought for Dementia Care Mapping (DCM) Training, for which the University of Bradford holds the licence. Non-approval this week would result in the return of £18,000 to NHSCT, likely lost by year end, and the loss of a long-sought opportunity to train staff in specialist assessment skills for patient care. The course is essential to delivering the BCUHB Annual Delivery Plan, where dementia education is the second Dementia Priority with Q4 objectives reportable to the Board. After three months of work to secure approval, non-approval would cause significant additional stress and result in failure to meet Welsh Government and NHS Executive expectations for this programme. Statement by Gethin Barlow
2025/2026-1601	24/11/2025	Estates and Facilities	Fujifilm	Temporary installation of a Fuji mammography system owned by BCUHB (currently in storage with Fuji) at Wrexham Maelor Hospital to provide an interim mammography service whilst the static mammography system is being replaced. This BCUHB owned Fuji system which is in storage during the refurbishment of Llandudno Community Hospital can be temporarily installed to provide Rapid Access Breast Clinics during the static replacement but only Fuji as the original manufacturers can complete this work and provide training to the Wrexham clinical team.	Genuinely one provider	£22,645.95	Accept	Procurement Services support this waiver request due to the sole supplier nature of the requirement. Fujifilm Healthcare UK Ltd are the Original Engineering Manufacturer of this equipment and the only provider that is able to facilitate the temporary installation whilst work is completed at Llandudno General Hospital.

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
2025/2026-1607	31/10/2025	Corporate	Better	Programme Board previously approved the use of a Sandbox environment until 31st March 2026, as outlined in the paper ePMA – SBAR Request for Sandbox v1.4. This was supported by a Single Tender Waiver (2025/2026-1597), which has since lapsed due to expiry of the original quotation. Procurement colleagues have confirmed there is no alternative route to market. To proceed, a new request is required. The supplier has advised that the original delivery window has passed and they will now need to source resources outside their allocated team, which incurs additional cost. The revised cost has been approved by Programme Board and remains within the financial envelope for the current financial year. Separately, an eLearning module was previously commissioned and delivered under Programme Board approval. Following review, further amendments are now required to reflect updated workflows and training needs. These changes also incur additional cost and cannot be resourced internally due to current capacity constraints. The ePMA Programme Board has approved the use of external contractors to undertake the necessary amendments, ensuring continuity of training delivery	Genuinely one provider	£21,745.00	Accept	Procurement supports this waiver on the basis that no other provider can fulfil this requirement as it is directly linked to the EPMA system with is provided by Better.

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
				and alignment with system deployment timelines.				
2025/2026-1608	17/12/2025	IHC Centre (Area Team - Central)	St. Johns	Training	Part of an extended pilot of roll out of Falls training, endorsed and supported by the NHS P and I team and UEC Six Goals lead (Richard Bowen)	£16,390.00	Accept	Procurement Support the following waiver. The training requirement arises from an initial pilot which has already been rolled out across all Health Boards within Wales. The provider has a nationally agreed and tested training package and going to open market would delay the Health Boards ability to mobilise the training to care homes across North Wales within the allocated period of Welsh Government funding. Additionally, an alternative provider and training solution would create further challenges and hinder the national evaluation of impact.
2025/2026-1613	17/12/2025	Estates and Facilities	Starkstrom	The supply, repair & replacement and commissioning of pendant items, within HDU North, HDU South & Surnicc special care baby unit at Glan Clwyd Hospital – following failure of the existing components effecting the control and movement of the pendent resulting in loss of bed spaces due to unplanned movement of pendent.	Genuinely one provider	£7,900.75	Accept	Procurement Services support this waiver request based upon Starkstrom being the Sole Supplier of this essential equipment and associated works. Award of this work to Starkstrom is recommended to ensure no delays in the equipment replacement and to mitigate any risk of warranty implications.

ASESIAD / Assessment	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	1. Building an effective organisation
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not Applicable.

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>Not Applicable.</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:	Not Applicable
<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 Data to Knowledge	Meysydd Ansawdd Domains of Quality Effective
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:

	If more than one applies, please list below:	If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	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:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog 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?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not applicable.
	If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not applicable.
	If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment Have you considered the counter fraud impacts	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not applicable.
	If no, please include rationale:	

	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.	

Audit Committee

ADRODDIAD GWRTH-DWYLL CH3 2025-2026 COUNTER FRAUD Q3 2025-2026 REPORT

Dyddiad y Cyfarfod Date of Meeting	17 February 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	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
Members are asked to: NOTE the summary 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
Not applicable for this report		

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms	
Not applicable for this report	

1. **Y SEFYLLFA SITUATION**

- 1.1 This report provides an overview of operational work, risks and proactivity undertaken by the BCUHB Counter Fraud Team in Q3 2025-2026. The local counter fraud service (LCFS) continues to deliver its workplan in line with NHS Counter Fraud Authority (NHSCFA) standards.
- 1.2 A new Band 6 Local Counter Fraud Specialist has been appointed to strengthen team capacity as we enter Q4. Progress on the workplan has continued but has been impacted by sickness absence within the team.

2 **Y CEFNDIR BACKGROUND**

- 2.1 Dashboard figures for Q3 2025/26 show:

	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25-26
Cases Open at end of Qtr	22	27	19	33
Cases Closed during Qtr	8	17	16	0

The dashboard in Appendix A will provide an outline of performance figures for Q3 2025-2026.

- 2.2 Review of the open cases shows a broad spread of allegations across:
- Working whilst sick
 - Timesheet/overtime fraud
 - GP and primary-care-related concerns
 - Patient fraud and misuse of NHS services

Working whilst on sick leave remains the most frequently reported fraud concern to the Local Counter Fraud Team, accounting for approximately one third of all referrals. A significant proportion of these reports relate to employees absent due to stress who are undertaking alternative work; while not all such cases meet the threshold for fraud, some do. In response, a targeted awareness campaign has been launched to educate staff on the risks associated with working whilst off sick and to clarify when such activity may or may not be appropriate. Undertaking work whilst on sick leave is likely to constitute a breach of contractual terms and, in certain circumstances, may amount to fraud.

- 2.3 The BCUHB Counter Fraud Team have contributed nationally to the refresh of the All-Wales Fighting Fraud Strategy, collaborating with Welsh counter-fraud leads on priorities, risk typologies and intelligence processes.

The draft Fighting Fraud Strategy will next be presented to the Deputy Directors of Finance group and thereafter to the Directors of Finance and Welsh Government for approval.

- 2.4 Proactive activity continued at reduced output due to staffing pressures, with two proactive exercises in progress, one completed, and five risk reviews completed. Details of proactive exercises will be provided to the private audit committee session. There were no Counter Fraud Clinics in Q3, however two will take place (at Ysbyty Gwynedd and Ysbyty Wrexham Maelor) in early March 2026.
- 2.5 The Counter Fraud Workplan for 2026-2027 has been completed and will be presented to the Executive Committee for approval at the next available date. Thereafter the workplan will be presented to the Audit Committee for final approval in April 2026.

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

3.1 **Organisational Counter Fraud Risk Assessment**

Executive Directors have been asked to identify risk owners within their area of responsibility in order to contribute to the Organisational Fraud Risk Assessment. The completion of the assessment will assist in ensuring that the organisation is able to evidence sufficient measures to prevent prosecution under the Failure to Prevent Fraud offence under the Economic Crime and Corporate Transparency Act 2023.

There are no matters for escalation from this paper.

4 **ARGYMHELLION** **RECOMMENDATIONS**

- 4.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:
- **NOTE** the summary provided

5 **APPENDICIES**

- 5.1 Appendix A - Counter Fraud Dashboard Q3 25-26

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>Answadd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> <u>Quality</u>	Galluogwyr Answadd Enablers of Quality All Apply Na	Meysydd Answadd Domains of Quality All Apply

Have you undertaken a Quality Impact Assessment Screening?	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:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	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 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?	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Do/Yes: ☐	Naddo/No: ☒



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>	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 Q3 25-26

Cases Under Investigation

33

Referrals Received

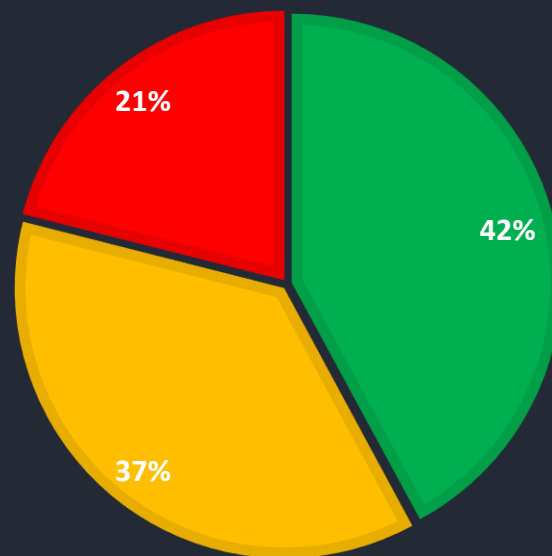
14

Interviews Under Caution

1

PROGRESS SINCE LAST UPDATE

■ Good ■ Acceptable ■ None



Subtype	Cases
Working Whilst Sick	11
Employee Fraud	7
Timesheet/overtime fraud	5
GP Practice	3
NHS Patients - Misuse of services	3
Post contract fraud - Invoicing fraud	2
Employee declaration	1
Staff collusion - Bribery	1
GP Practice - Diversion of global sum	1



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Investigation Outcomes – Q3 25-26

Cases Closed

0

Referrals to Other Agency

3

Loss Identified

£4823.24

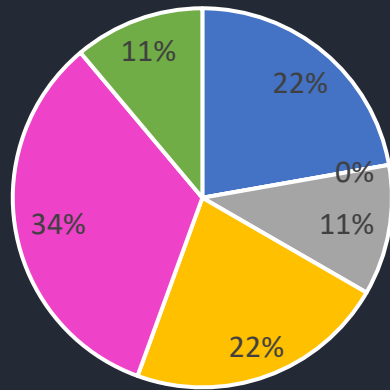
Loss Recovered

£5323.24

Loss Prevented

£20,633.95

SANCTIONS/OUTCOMES



Disciplinary

Criminal Prosecution

Caution/Community Resolution

Civil Recovery

Referral to Other Agency

DoI Requested

Fraud Identified in
31.19%
Of Cases

Sanctions/Outcomes
Applied
9

Average Days to Investigate
242



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Proactive Work – Q3 25-26

E-Learning Training Compliance

91.39%

Risk Reviews

5

Presentations

0

Media Reports

2

System Weakness
Reports Completed

0

Local Proactive
Exercises Completed

2

Local Proactive
Exercises in Progress

1

Engagement Events
(People Seen)

0



Audit Committee

ADRODDIAD CYNNYDD ARCHWILIO MEWNOL INTERNAL AUDIT PROGRESS REPORT

Dyddiad y Cyfarfod Date of Meeting	17 February 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, CMIIA Nicola Jones, Deputy Head of Internal Audit, CMIIA
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 progress report summarises three reviews finalised since the last Committee meeting in December 2025, with the recorded assurance as follows: - Reasonable assurance – one - Limited assurance – two The report also provides the status of the 2025/26 Audit 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

CHC	Continuing NHS Healthcare
IRCF	Integrated Regional Care Fund
RAH	Royal Alexandra Hospital
NICE	National Institute for Health and Care Excellence
IA	Internal Audit
SOP	Standard Operating Procedure
DDaT	Digital Data and Technology Directorate

INTERNAL AUDIT PROGRESS REPORT

1. **Y SEFYLLFA SITUATION**

- 1.1 This 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 2025/26 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; Value and Sustainability – delivering quality outcomes, and Estate Management – estates and facilities alerts.
- 3.2 Executive agreed management response rates to draft internal audit reports have deteriorated from 64% to 57%.

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

- 4.1 There are no specific risks other than those relating to individual reviews / findings.

5 **ARGYMHELLION RECOMMENDATIONS**

- 5.1 The Committee is asked to note the findings within the progress report and associated audit reports.

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. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Socio-Economic duty is not applicable. This progress report is required per the Welsh

<i>Have you undertaken a Socio-Economic Impact Assessment</i>		Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	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	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
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 Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Armed Forces Covenant Due Regard duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5

		Reviewing internal audit assignment reports.
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 is no identifying information included in the progress report or reports.
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:	Counter Fraud considerations are taken into account for all relevant audit reviews.
	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.	

Internal Audit Progress Report

Audit Committee

2 December 2025 to 2 February 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 2025/26.

Reports Issued

Since the last progress report, three reviews have been issued as final.

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
Primary Medical Care – Contract Assurance Framework (BCU-2526-22)	Reasonable	The review examined how the Health Board is implementing the new Contract Assurance Framework for managing primary medical care contracts and found reasonable assurance with positive early progress. However, improvements are needed around agreeing local priorities, strengthening evidence to support practice self-assessments, and ensuring clearer reporting of contract compliance to the Health Board.
Value and Sustainability – Delivering Quality Improvements (BCU-2526-07)	Limited	The review found that while the Health Board has strong systems for tracking and reporting financial savings, it lacks processes to assess the wider non-financial impacts of Value and Sustainability schemes, such as quality, outcomes, and patient or staff experience. As a result, only limited assurance could be given, with key issues including inconsistent financial analysis, missing evaluation of non-financial benefits, and gaps in documentation within savings submissions.
Estate Management – Estates and Facilities Alerts (BCU-2526-31)	Limited	The review examined how the Health Board manages Estates and Facilities Alerts and found limited assurance, with significant gaps in oversight, governance, and follow-up. Key weaknesses include the absence of a formal SOP, no central group providing assurance, and inconsistent tracking of actions, with several alerts showing no evidence of implementation.

Image 1: Summary of final report assurance ratings issued as of 2 February 2026

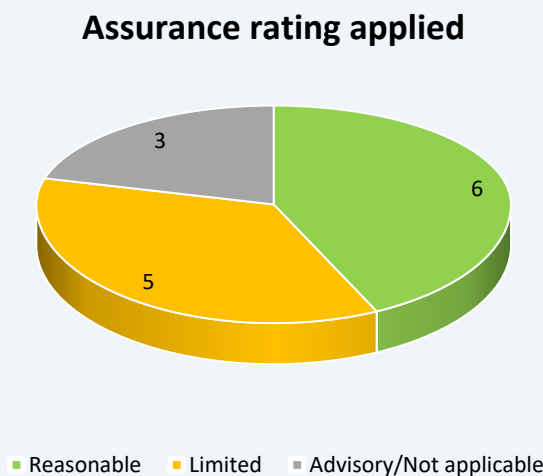


Table 4 details the status of all reviews in the 2025/26 plan.

Follow-up

The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. We have reviewed 47 recommendations, with the outcomes noted in the table below.

Table 2 – Status of follow-up actions submitted for closure

Recommendation category by submission	Number of recommendations	Closed	Partially closed	Outstanding
Submitted for 1 st review	26	9 (35%)	9 (35%)	8 (30%)
Submitted for 2 nd review	15	9 (60%)	4 (27%)	2 (13%)
Submitted for 3 rd review	6	4 (66%)	1 (17%)	1 (17%)
TOTALS	47	22 (47%)	14 (30%)	11 (23%)

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 also participate in the All Wales Direct Payments for Continuing NHS Healthcare (CHC) Implementation Task and Finish Group, which the Health Board is leading.

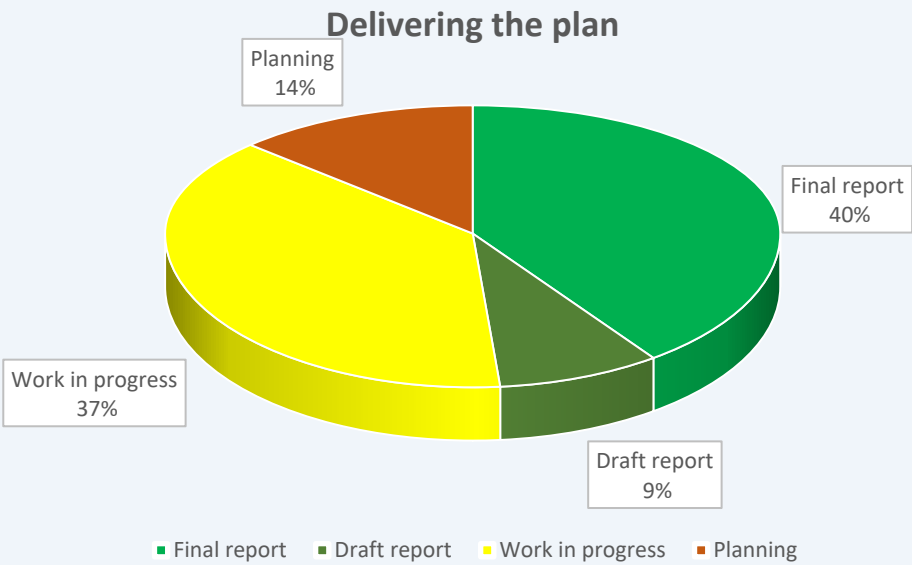
We have met with the Director of Corporate Governance in this reporting period.

Planning for the 2026/27 has progressed, with areas of risk identified and presented to the Executive Team on 7 January 2026. Following feedback from Executives, due 9 February 2026, an outline plan will be drafted and shared with the Chief Executive Officer and Director of Corporate Governance in the first instance. The plan will be presented to the Audit Committee in April for review and approval.

Delivering the plan

The status of the 2025/26 internal audit plan is detailed in image 2 (excluding proposed additions to the plan).

Image 2: Current status of plan delivery



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 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).

For 2025/26, fourteen reports have been issued as final, with six missing the management response timeline.

Table 3 is reporting a positive status across all indicators except for plan delivery and report turnaround time, which has deteriorated from 64% to 57%. Figures are based on reports issued as final.

Table 3: Performance Indicators

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2025/26		4 March 2025	30 June
Total audit reviews reported against adjusted plan for 2025/26		14	16
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100%	80%

Indicator	Status	Actual	Target
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		57%	80%
Report turnaround: time from management response to issue of final report [10 days]		100%	80%
Key  v>20%  10%<v<20%  v<10% :			

Table 4: Core Plan 2025/26

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
1. Risk Management and Board Assurance Framework (Assurance)	Work progress.	in April 2026	
2. Follow up	Work progress.	in On-going	
3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance)	Final report.	October 2025	Limited
4. Standards of Business Conduct (Assurance)	Work progress.	in April 2026	
5. Executive Committee Governance (Assurance)	Brief agreed.	April 2026	
6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance)	Final report.	October 2025	Reasonable
7. Value and Sustainability – delivering quality improvements (Assurance)	Final report.	October 2025	Limited
8. Budgetary Control and Financial Reporting (Assurance)	Deferred.		-
9. Budget Setting (All Wales review) (Assurance)	Work progress.	in April 2026	
10. Patient Experience (Assurance)	Final report.	October 2025	Reasonable
11. Learning – Regulatory reporting (Assurance)	Final report.	October 2025	Limited
12. Outpatient Transformation (Assurance)	Deferred.		-
13. Complaints (Assurance)	Final report.	December 2025	Reasonable
14. Skills and Capabilities (Assurance)	Deferred.		-
15. Delivering successful change and benefits realisation (Assurance)	Final report.	December 2025	Reasonable
16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance)	Work progress.	in April 2026	

¹ Subject to change

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
17. Community Services (Assurance)	Final report.	December 2025	Reasonable
18. Productivity and Efficiency (Assurance)	Deferred.		-
19. Planned Care Major Change Programme (Assurance)	Work progress. in	April 2026	
20. Urgent Emergency Care (Assurance)	Planning.	June 2026	
21. Primary Dental Care (Assurance)	Deferred.		-
22. Primary Medical Care – Contract Assurance Framework (Assurance)	Final report.	February 2026	Reasonable
23. Workforce Planning (Assurance)	Deferred		-
24. Culture and Leadership Development (Assurance)	Work progress. in	April 2026	
25. Speaking Up Safely (Assurance)	Work progress. in	April 2026	
26. On-call arrangements (Assurance)	Draft report.	February 2026	Limited
27. Consultant Job Planning follow up	Final report.	October 2025	Assurance not applicable
28. NICE guidance compliance (Assurance)	Draft report.	February 2026	Limited
29. Agency utilisation (Assurance)	Deferred.		-
30. Challenged Care services (Assurance)	Brief agreed.	April 2026	
31. Estate Management – Estates and Facilities Alerts (Assurance)	Final report.	February 2026	Limited
32. Statutory Compliance: Asbestos Management (Assurance)	Work progress. in	April 2026	
33. Capital Systems (Assurance)	Deferred.		-
34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance)	Deferred.		-
35. Integrated Regional Care Fund (IRCF) Projects (Assurance)	Deferred.		-
36. Falls Management follow up	Final report.	August 2025	Assurance not applicable
37. Contract management and procurement – Digital Data and Technology (Advisory)	Final report.	August 2025	Advisory
38. Contract management and procurement – Executive and Director corporate functions (Assurance)	Final report.	December 2025	Limited
39. Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (Assurance)	Deferred.	June 2026	-
40. Pharmacy regulatory compliance	Brief agreed.	April 2026	

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
41. Sickness management	Brief issued.	June 2026	
42. Purchase cards & Petty cash	Work progress. in	April 2026	
43. Major Project Governance and Contract Management Arrangements	Work progress. in	April 2026	
44. Centre for Mental Health and Society	Draft report.	April 2026	Advisory
45. Integrated Audit Plan – Nuclear Medicine	Work progress. in	TBC	
46. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub	Work progress. in	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.

Disclaimer

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

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Betsi Cadwaladr University Health Board – Audit Committee Update

Date issued: February 2026



Contents

Contents	2
Introduction	4
Accounts audit update	5
Performance audit update	6
Other relevant publications	9
Further information	11

This document has been prepared as part of work performed in accordance with statutory functions.

The Auditor General, Wales Audit Office and staff of the Wales Audit Office accept no liability in respect of any reliance or other use of this document by any member, director, officer or other employee in their individual capacity, or any use by any third party.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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 most recent Audit Plan to the committee in March 2025.

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 2024-25 Awyr Las Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2024-25 Audit of Awyr Las Annual Report and Accounts.
 - **Status:** Completed
 - **Committee date:** 28th January 2026

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:** Planning work ongoing
 - **Expected committee date:** 23rd June 2026

Performance audit update

Structured assessment 2025 – core

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment reviewed:
 - Board and committee cohesion and effectiveness;
 - Corporate systems of assurance;
 - Corporate planning arrangements; and
 - Corporate financial planning and management arrangements.
- **Status:** In clearance discussions with the Health Board.
- **Expected committee date:** April 2026

Use of the strategic financial assistance provided by the Welsh Government for the period October 2020 onwards

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This audit will encompass a high-level examination of the Health Board's arrangements for using the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.
- **Status:** In clearance discussions with the Health Board.
- **Expected committee date:** April 2026

Review of quality governance arrangements

- **Executive Leads:** Executive Director of Nursing, Executive Medical Director and the Executive Director of Allied Health Professionals and Health Science.
- **Focus of the work:** This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.
- **Status:** Drafting

Expected committee date: April 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Fieldwork in progress
- **Expected committee date:** June 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** This work will examine 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:** Fieldwork in progress
- **Expected committee date:** August 2026

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider:
 - The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
 - The efficacy of local plans and associated actions to recover cancer waiting lists; and
 - Use of the additional Welsh Government financial allocations to improve cancer services.
- **Status:** Planning
- **Expected committee date:** August 2026

Other relevant publications

Over the past three months, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

<u>Checking the patients. Results from a pilot data matching exercise on GP patient lists</u>	January 2026
<u>Positive action on fraud and error in community pharmacy but more analysis could reap rewards</u> (news article)	December 2025
<u>Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028</u>	December 2025
<u>Facing the Future – Auditor General for Wales Podcast – Episode 4</u>	November 2025
<u>Opportunities for Change – Auditor General for Wales Podcast – Episode 3</u>	November 2025
<u>Under Pressure – Auditor General for Wales Podcast – Episode 2</u>	November 2025
<u>A Unique Perspective – Auditor General for Wales Podcast – Episode 1</u>	November 2025

Since the last committee update, Audit Wales has also published the following corporate document.

[Fee Scheme 2026-27](#)

January 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



[Data tools](#) to help you better understand public spending trends.



Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.



Our [newsletter](#) which provides you with regular updates on our public service audit work, good practice, and events.



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.

