

## Bundle Audit Committee 15 March 2024

- 1 OPENING ADMINISTRATION – OPEN SESSION
  - 1.1 09:30 – AC24.34 Welcome, introductions and apologies for absence  
*Chair – for information.*  
*Verbal Report*
  - 1.2 09:32 – AC24.35 Declarations of interest on current agenda  
*Chair – for decision.*  
*Verbal Report*
  - 1.3 09:34 – AC24.36 Minutes of previous meeting for accuracy & matters arising and review of summary action plan  
*Chair for approval.*  
*The Committee is asked:*  
*To confirm the Minutes of the last meeting as a correct record and to discuss any matters arising; and*  
*To review the Summary Action Log*
    - AC24.36a Draft Minutes AC 12.01.24 – Public session V.4
    - AC24.36b Table of Actions – Public Session – updated
  - 1.4 09:36 – AC24.37 Notification of matters referred from other Committees  
*Phil Meakin, Acting Board Secretary – for decision.*  
*Verbal Report*
- 2 GOVERNANCE
  - 2.1 09:42 – AC24.38 Special Measures Progress Update on relevant areas  
*Paolo Tardivel – Director of Transformation & Improvement – in attendance to present.*  
*The Committee is asked to*  
*Receive Assurance on the progress to date, acknowledging the challenges highlighted and risks to delivery.*
    - AC24.38 Special Measures
  - 2.2 09:57 – AC24.39 Risk Management  
*Phil Meakin, Acting Board Secretary / Nesta Collingridge, Head of Risk Management – for assurance*  
*The Committee is asked to:*  
*Note and receive assurance for:*  
*Chair’s Assurance Report from the Risk Management Group (full assurance).*  
*Board Assurance Framework (full assurance).*  
*Corporate Risk Register (partial assurance).*  
*Any agenda items deriving from the BAF & CRR.*
    - AC24.39 Final V1 –AC Corporate Risk Register Board Assurance Framework and RMG
  - 2.3 10:12 – AC24.40 Corporate Governance  
*Phil Meakin – Acting Board Secretary to present.*  
*The Committee is asked to:*  
*Note the report on breaches to Board and Committee agenda and papers.*  
*Note and Approve the “Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents.”*  
*Note the progress being made on updating policies.*  
*Note the update on Declarations of Interest and Gifts and Hospitality.*
    - AC24.40 Corporate Governance Cover sheet & Report
    - AC24.40 Appendix 1 Breach log Audit March 2024 (004)
    - AC24.40 Appendix 2 – DRAFT – OBS01 – PoP V01.06 28 Feb (003)
- 3.0 FINANCE
  - 3.1 10:27 – AC24.41 Breaches of SFI’s, Scheme of Delegation and SO’s  
*Russell Caldicott, Interim Executive Director of Finance – for assurance.*  
*Verbal*
  - 3.2 10:32 – AC24.42 SFI Conformance Report: period ending December 24  
*Russell Caldicott, Interim Executive Director of Finance – for assurance.*  
*Verbal*

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

*The Committee is asked to:*

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

*Note the initial key areas where the values recorded in the 2023/24 Annual Accounts will be based on a judgement (estimation). Further details will be shared at the planned Audit Committee Development Session on the 21st May 2024.*

AC24.43 2023/24 Accounts timetable & Judgements – R

3.4 10:57 – AC24.44 Counter Fraud Report (Matters for Public)  
*Karl Woodward, Head of Local Counter Fraud Services – for assurance.*  
*Verbal*

3.5 11:02 – COMFORT BREAK

4.0 INTERNAL AUDIT

4.1 11:12 – AC24.45 Internal Audit Reports

*Dave Harries, Head of Internal Audit to present.*

*Russell Caldicott Executive Director of Finance – (Audit /Report Reviews).*

*The Committee is asked to:*

*Plan*

*Approve the six-month Internal Audit Plan for April to September 2024.*

*Note the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2024/25.*

*Approve the Internal Audit Charter.*

*Note the associated Internal Audit Key Performance Indicators.*

*Progress report*

*Receive the progress report.*

AC24.45 – Coversheet – IA progress report Cover Sheet\_March24

AC24.45 Appendix 1 – BCUHB Internal Audit plan 2024–25

AC24.45 Appendix 2 – BCUHB Audit Committee progress report March 2024

AC24.45 Appendix 3 – BCUHB Final Follow Up Report Delivery of Health Board Savingsv2

AC24.45 Appendix 4 – Final Internal Audit Report Water Safety

4.4 11:32 – AC24.46 Audit Recommendations Tracker

*Phil Meakin, Acting Board Secretary / NESTA Collingridge, Head of Risk Management – for assurance – to present.*

*In attendance to update the Committee;*

*Angela Wood, Executive Director of Nursing and Midwifery*

*Adele Gittoes, Executive Director of Operations*

*The Committee is asked;*

*to note the current position (February 2024) of overdue audit recommendations*

*take assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations*

*to consider proposed recommendations for closure.*

AC24.46 Audit Tracker Report v1.00

AC24.46 App 1 – all open External Recommendations v1.00

AC24.46 App 2 – All open internal recommendations v1.00

AC24.46 App 3 – All recommendations proposed for closure v1.00

AC24.46 App 4 – Outstanding or incomplete updates v1.00

4.5 11:52 – AC24.47 COMFORT BREAK

5.0 EXTERNAL AUDIT

5.1 12:02 – AC24.48 Audit & Risk Committee Update

*Andrew Doughton, Audit Wales Lead – for update and discussion.*

AC24.48 Audit Committee Update – March 2024

5.6 12:17 – AC24.49 Board Effectiveness Follow up

*Fflur Jones, Audit Wales – to present for information*

*The purpose of this report is to provide Audit Committee with:*

*The Audit Wales report on the follow-up review of board effectiveness report and to provide the Health Board's response to the report's findings and recommendations*

AC24.49 Coversheet for Board Effectiveness reports

AC24.49 Appendix 1 – Full Report Board Effectiveness Follow-up Betsi Cadwaladr University Health Board – English

AC24.49 Appendix 2 – Health Board Response to Board Effectiveness Follow up Report'

6.0 AUDIT COMMITTEE

- 6.1 12:32 – AC24.50 Briefings And Update Sessions (As Appropriate)  
*Chair/Acting Board Secretary – for information*  
*Verbal*
- 7 CLOSING BUSINESS
- 7.1 12:42 – AC24.51 Agree Items for referral to Board / other Committees  
*Chair – for information*  
*Verbal*
- 7.2 12:47 – AC24.52 Review of Risks emerged in the meeting for referral to Risk Management Group  
*Chair – for information*  
*Verbal*
- 7.3 12:52 – AC24.53 Agree items for Chairs Assurance Report  
*Chair – for information*  
*Verbal*
- 7.4 12:57 – AC24.54 Review of Meeting Effectiveness  
*Members – for information*  
*Verbal*
- 7.5 13:05 – AC24.55 Date of Next Meeting 7th May 2024  
*Chair – for information*  
*Verbal*
- 7.6 13:10 – AC24.56 Exclusion of Press and Public  
*Resolution to Exclude the Press and Public – "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."*

## Betsi Cadwaladr University Health Board

### Draft minutes of the Audit Committee held on 12 January 2024, Boardroom, Carlton Court, St Asaph

<b>Present</b>	
<b>Name</b>	<b>Title</b>
Karen Balmer	Independent Member (IM), Chair
Urtha Felda	Independent Member
Dyfed Jones	Independent Member
<b>In attendance</b>	
Andrea Hughes	Interim Director of Finance
Carol Shillabeer	Chief Executive
Danielle Hunt	Senior Risk Management Administrator (for minutes)
Dave Harries	Head of Internal Audit
Fflur Jones	Audit Lead, Audit Wales
Glesni Driver	Head of Covid-19 Inquiry
James Risley	Deputy Executive Medical Director
Karl Woodward	Head of Local Counter Fraud Services
Matthew Joyes	Deputy Director of Quality
Nesta Collingridge	Head of Risk Management
Nicola Jones	Deputy Head of Internal Audit
Nick Graham	Associate Director Workforce Optimisation
Paolo Tardivel	Director of Transformation & Improvement
Phil Meakin	Acting Board Secretary
Rhys Blake	Associate Director of Planned Care
Russell Caldicott	Interim Executive Director of Finance
Simon Monkhouse	Audit Lead, Audit Wales
<b>Observing</b>	
Elin Davies	Student
Fiona Lewis	Corporate Business Officer

<b>Agenda item</b>	<b>Action</b>
<b>OPENING BUSINESS</b>	
<b>AC24/1 Welcome introductions and apologies</b>	
AC24/1.1 The Chair of the Committee welcomed everyone to the meeting.	
AC24/1.2 Apologies were received from; the Executive Medical Director - for whom the Deputy Executive Medical Director deputised, the Deputy Director of People – for whom the Associate Director of Workforce Optimisation deputised, the Interim Executive Director of Operations – for whom the Head of Covid-19 inquiry deputised, the Executive Director of Transformation and Strategic Planning – for whom the Deputy Director of Transformation and Improvement deputised and the Executive Director of	

<p>Nursing and Midwifery – for whom the Deputy Director of Quality deputised.</p>	
<p><b>AC24/2 Declarations of interest on current agenda</b></p> <p>AC24/2.1 There were no declarations of interest.</p>	
<p><b>AC24/3 Draft Minutes of the meeting held on 15 September 2023 and review of summary action log</b></p> <p>AC24/3.1 The Committee approved the draft minutes subject to the following amendments:</p> <ul style="list-style-type: none"> <li>• Page 1 – Andrew Doughton’s job title</li> <li>• Page 3 – Action to be assigned to PM</li> <li>• Page 13 – Revise to read “ongoing post project”</li> </ul> <p>AC24/3.2 The table of actions was updated, along with the items for closure as advised. It was noted that AC23.120 should read January 2024. The Committee sought clarity on action AC23.08.5G and were advised by the Head of Internal Audit that this related to a Limited Assurance Report on the Charitable Funds with regard to the purpose of the charity. It was agreed that the Interim Executive Director of Finance would attain the Charitable Funds Articles of Association for review at the next meeting.</p> <p>AC23.62 It was noted that the topic of sustainability would reside with the recently established Planning Population and Health Partnerships (PPPH) Committee and accordingly the action will now be closed.</p> <p>AC24/3.3 In regard to Action 9, the Committee Chair was advised that the Head of Health and Safety had confirmed the assurances provided met the criteria for reporting RIDDOR. The CEO also advised that she held regular meetings with the Health and Safety Executive who were happy with the risk assessments that were in place alongside active planning. IM – Urtha Felda noted that there needed to be a balance of good practice versus risk when trying to get people back on their feet. The CEO further added that a gap analysis was underway that would include key areas such as RIDDOR Reporting and that Internal Audit would be conducting a review of Health &amp; Safety.</p> <p>AC23.124 – The AC chair advised that she had anticipated that, given the previous meeting’s discussion, the updated Follow up Outpatients response would have been shared with the Committee as part of the papers. On the Chair’s request a copy of the response was available for Committee Members at the Meeting.</p>	<p>RC</p>



ITEMS FOR APPROVAL OR ASSURANCE	
<p><b>AC24/4 Audit Committee Terms of Reference (ToR) and Cycle of Business (CoB) 24/25</b></p> <p><b>AC24/4.1</b> The Acting Board Secretary presented the item. He summarised the amendments to the ToR and invited members to provide any feedback.</p> <p><b>AC24/4.2</b> The Head of Internal Audit (HoIA) advised that he had raised with the Interim Board Secretary (prior to the Committee meeting) that there appeared some areas that required review to ensure the Committee Terms of Reference are in line with the Model Terms of Reference included in the NHS Wales Audit Committee Handbook. The HoIA advised that he would provide details to the Interim Board Secretary in accordance with the timelines required for the next Health Board meeting.</p> <p><b>AC24/4.3</b> Comment was also noted around the '<i>Committee Vice Chair</i>' advising that the appointment nomination would be confirmed at next Audit Committee.</p> <p><b>AC24/4.4</b> The Acting Board Secretary advised the draft CoB was provided for information and would be developed further following feedback provided by the Committee.</p> <p><b>It was resolved that the Committee reviewed and endorsed</b></p> <ul style="list-style-type: none"> <li>• the draft Terms of Reference for the Audit Committee subject to HoIA recommended amendments</li> <li>• the Cycle of Business for the Audit Committee.</li> </ul> <p><b>agreed</b></p> <ul style="list-style-type: none"> <li>• the Acting Board Secretary to update 4.2 re 'Accountable Officer' being 'Chief Executive Officer'.</li> </ul>	<p>PM</p> <p>PM</p>
<p><b>AC24/5 Corporate Governance Arrangements</b></p> <p><b>AC24/5.1</b> The Acting Board Secretary advised meetings had taken place with the Chair and Lead Directors of each Board Committee to consider Committee Terms of Reference and Cycles of Business, which would be submitted to the Board for approval on 25<sup>th</sup> January 2024.</p> <p><b>AC24/5.2</b> The Committee was advised that a further update on the Policy on Policies consultation would be provided to the March Audit Committee meeting for review prior to submission to the Health Board. It was noted that work was ongoing to address out of date policies and standard operating procedures at the earliest opportunity and their submission for approval via the appropriate governance route. The Interim Executive Director of Finance was keen to emphasise that Policies were in place to protect staff and any amendments were important to document effectively.</p>	

<p><b>AC24/5.3</b> The Committee received assurance that the Breach Log would be regularly submitted and the Standard Operating Procedure was to be reviewed by the Acting Board Secretary, in order to provide a more robust system to ensure officers would be held to account for papers submitted late to Committees or the Health Board, in contravention of the Health Board's Standing Orders.</p> <p><b>AC24/5.4</b> An update was provided on Declarations of Interest/Gifts &amp; Hospitality Implementation Plan. The Head of Counter Fraud provided examples of DOIs submitted. A discussion ensued in which it was agreed that the Acting Board Secretary would enhance future DOI updates as discussed e.g. per banding declarations.</p> <p>It was resolved that the Committee</p> <ul style="list-style-type: none"> <li>• <b>noted</b> acceptable assurance on the Committee governance developments update, including ToRs and COBs.</li> <li>• <b>noted</b> the latest consultation feedback on the Policy for Policies</li> <li>• <b>noted acceptable assurance</b> on the details of Breaches of Standing Orders</li> <li>• <b>noted partial assurance</b> on the Declarations of Interests/Gifts and Hospitality Implementation update report.</li> </ul>	<p>PM</p>
<p><b>AC24/6 Ombudsman Review</b></p> <p><b>AC24/6.1</b> The Deputy Director of Quality introduced the report and outlined the key aspects. He described ongoing work between his team and the Ombudsman, advising that the current backlog of 290 complaints which were overdue (response within 30 days) was being addressed. Assurance was provided by the Head of Risk Management that this had been identified as a new risk on the Corporate Risk Register which had been assigned to the Quality, Safety and Experience Committee (QSE) for oversight.</p> <p><b>AC24/6.2</b> It was noted that quarterly meetings are held with the ombudsman and that the CEO meets twice a year, it was also noted that the (QSE) oversee actions arising from the Ombudsman reports.</p> <p><b>It was resolved that the Committee noted the report</b></p>	
<p><b>AC24/7</b> No item</p>	
<p><b>AC24.8 Risk Management</b></p> <p><b>a) Assurance report RMG Corporate Risk Register</b></p> <p><b>AC24.8.1</b> The Head of Risk Management introduced this report and briefly</p>	

<p>summarised some progress being made with this work.</p> <p>AC24.8.2 The Head of Risk Management outlined key metrics from the Risk management performance report identifying improvements required across BCUHB, aligning this to the Risk Management Framework.</p> <p>AC24.8.3 The Acting Board Secretary summarised part of the report in relation to the corporate risk on Leadership for whom the owner is the Deputy Director of People and assure members that this risk is assigned to Audit Committee.</p> <p>AC24.8.4 Head of Internal Audit provided feedback on the adequacy of some of the controls in place for this risk.</p> <p>AC24.8.5 Action - It was agreed by the Committee and those in attendance that the risk register overview should provide more of a dashboard approach, so that movement in progress could be monitored and a RAG status included to provide instant visibility of progress or otherwise.</p> <p><b>b) Board Assurance Framework</b></p> <p>AC24.8.6 The Head of Risk Management introduced this report and briefly summarised the progress of this work.</p> <p>AC24.8.7 The Acting Board Secretary followed on from this to discuss in detail a risk involving special measures and assured the group that there is significant progress being made.</p> <p>AC24.8.8 Action – The Executive Lead for the Special Measures risk would continue to review and scrutinise the risk, in a challenged and balanced process.</p> <p>AC24.8.9 Action - It was agreed by the Committee and those in attendance that the Board Assurance Framework should provide more of a dashboard approach so that movement in progress could be monitored and a RAG status included to provide instant visibility of progress or otherwise.</p>	<p>NC</p> <p>PM</p> <p>NC</p>
<p><b>AC24.9 Special Measures Report</b></p> <p><b>a) Update on milestones and arrangements related to AC</b></p> <p>AC24.9.1 The Director of Transformation and Improvement welcomed this paper as read and introduced this report for assurance and briefly summarised some aspects of key points to members. He assured members there has been solid progress made in relation to milestones for this Committee including the appointment of permanent Board Members.</p>	

<p>AC24.9.2 Action – The Acting Board Secretary to work with the Director of Transformation and Improvement on this report specifically 21.9 policy arrangement and implementation to note some of the new timescales and capturing information correctly.</p> <p>AC24.9.3 The Committee noted that Cycle 3 commenced in the run up to the Christmas and New year period and therefore due to the reporting timetable for the committee, no milestone deadlines had become due. Assurance was received, however, that good progress was being made with cycle 3 deliverables and milestones.</p>	<p>PM/CS</p>
<p><b>AC24.10 Review annual accounting progress and note financial accounting timetable</b></p> <p>AC24.10.1 The Interim Executive Director of Finance introduced this report and briefly summarised this item and AC24.11 both together. He extracted some key points from the report for members, including positive engagement meetings with Audit Wales and preparation to close down financial accounts moving towards 31<sup>st</sup> March 2024.</p> <p>AC24.10.2 The Chair acknowledged the work done to ensure that the accounts would be produced within the agreed timeframes and took assurance from this report of the learning that had followed from the preceding financial year.</p>	
<p><b>AC24.11 SFI Conformance Report: period ending November 23</b></p> <p>AC24.11.1 The Interim Executive Director of Finance introduced this report and then the Interim Director of Finance indicated some key points from the paper to members. She then asked members to note and debate key points that were explained.</p> <p>AC24.11.2 The Interim Executive Director of Finance confirmed this item will be at Audit Committee as a standing item each time.</p> <p>AC24.11.3 The Chair commended the Interim Director of Finance for her report which was thorough and informative whilst remaining succinct. The Committee agreed that the report format and its content were of an excellent standard.</p> <p>AC24.11.4 The Committee acknowledged the work done by the Finance Team to reduce areas of non-compliance with the SFIs and in particular single tender waivers and single quotes.</p> <p>AC24.11.5 The level of Purchase Order breaches were noted and the Committee Chair suggested that a deeper dive into the reasons for this be instigated as part of the procurement, or as a standalone audit investigation by Internal Audit. Consideration to be given as to where this is best picked up.</p>	<p>RC</p>



<p><b>AC24.12 Key Assumptions and Judgements 23/24 Annual Accounts</b> AC24.12.1 The Interim Executive Director of Finance provided a verbal update advising that a detailed paper would be brought to the next committee meeting.</p>	RC
<p><b>AC24.13 Counter Fraud in Year Progress Report</b> AC24.13 Head of Local Counter Fraud Services highlighted the current reporting position of Q3 to Welsh Government.</p>	
<p><b>AC24.14 Internal and External Audit Tracker</b> AC24.14.1 The Head of Risk Management introduced this report and summarised a brief update on key points before introducing the Deputy Executive Medical Director and the Associate Director Workforce Optimisation to summarise their papers.</p> <p>AC24.14.2 The Chief Executive assured the Committee members that practice moving forward, will be that the management response to Audit recommendations will be considered by the Executive Team for review and scrutiny before being added to the tracker and that progress against the recommendations will be scrutinised at Executive Team Meetings.</p> <p>AC24.14.3 It was noted that items proposed for closure required robust evidence and that actions taken needed proof of embedding in business as usual before final sign off. The HoIA commented that in order to comply with Internal Audit Quality Standards Charter, they need to follow up ALL limited, unsatisfactory and no assurance recommendations, as well as high risk recommendations in audits rated reasonable.</p> <p>AC24.14.4 In relation to the closure of audit recommendations, the HoIA advised that Executive recommendation would need to be backed by Internal audit confirmation that the evidence provided was sufficient to warrant closure.</p> <p>AC24.14.5 The Chair noted that the timing of items presented for closure needed to be considered in light of the above. It was agreed that a discussion around this would take place before the next committee meeting.</p> <p><b>a) Executive Medical Directorate</b> AC24.14.6 The Deputy Executive Medical Director introduced his part of the report and assured members there are 8 recommendations proposed for closure.</p> <p>AC24.14.7 The Committee approved closure in principle subject to Internal Audit review, and then any of the closed items that are challenged be brought back to Audit Committee in March.</p>	PM NC



<p><b>b) People Services</b></p> <p>AC24.14.8 The Associate Director Workforce Optimisation introduced his part of the report and briefly describes that the closed items are there for any ratification from members.</p> <p>AC24.14.9 The Committee approved closure in principle subject to pending review and then any of the recommendations that are challenged to be brought back to Audit Committee in March.</p> <p>AC24.14.10 The Associate Director Workforce Optimisation described a number of open actions they have which have been reviewed over the last 12 months given changes to organisational maturity and expects a number of those actions will be submitted for closure by March Audit Committee.</p>	
<p><b>AC24.15 Internal Audit progress report</b></p> <p>AC24.15.1 The Head of Internal Audit introduced this report and briefly described some key points from the paper for members. It was noted that the management response time to the audit reports had dipped very slightly from 100% to 97% since the last report, which the committee anticipated to be a temporary glitch.</p> <p>AC24.15.2 The Deputy Head of Internal Audit further summarised and described aspects from the report including the reasonable audit models regarding digital operating model, mental health unit at YGC and the Welsh language commissioner follow up.</p> <p>AC24.15.3 The HoIA advised that the Internal Audit service was reviewed every 5 years via an external quality assurance assessor. The HoIA was very pleased to advise that the team had received the highest rating possible in these quality standards. The Chair of the Committee congratulated the Internal Audit Team on this achievement.</p>	
<p><b>AC24.16 Any no assurance or limited assurance reports as a substantive item</b></p> <p><b>a) Lessons Learnt</b></p> <p>AC4.16.1 The Deputy Director of Quality introduced this report and gave a brief description and explained that the review looked specifically at 'make it safe reviews' which will be rapid reviews of the most serious incidents. He also summarised some of the actions captured through the report and explained a bespoke system using the office 365 platform that is currently being progressed.</p> <p>AC24.16.2 In response to questions raised with regard to investment and ongoing maintenance of this system, the Interim Executive Director of Finance suggested this development is sighted in the Executive Team</p>	RC



<p>Meeting and that QSE has sight of the quality of the system.</p> <p><b>b) Decarbonisation</b> AC24.16.3 The Interim Executive Director of Finance introduced this report and summarised key points to members. He described in particular the level of engagement within the decarbonisation group that sit within the IHC's and All Wales funding has been allocated by Welsh Government for decarbonisation.</p> <p><b>Action</b> – The Acting Board Secretary to put decarbonisation on the PPPH Committee agenda.</p> <p><b>c) Waiting List Management</b></p> <p>AC24.16.4 The Committee were asked to note that this report went to the QSE Committee in 2022 and that members of the Committee at that time rejected the management response. Due to the changes that took place in February this report has not been brought back to the committee prior to now.</p> <p>AC24.16.5 Associate Director of Planned Care introduced this report and gave a summarised description to the members regarding outstanding actions from the internal audit into a national initiative led by Welsh Government around validation of waiting lists after Covid.</p> <p>AC24.16.6 The Head of Internal Audit recognised that progress has been made with some of the actions within this report</p> <p>AC24.16.7 The Head of Internal Audit asked for the approval of the Llandudno Orthopaedic work to which members approved.</p>	PM
<p><b>AC24.17 Auditor General's (external audit) update</b></p> <p>AC24.17.1 Fflur Jones of Audit Wales introduced this report and summarised key points to members.</p> <p>AC24.17.2 Simon Monkhouse of Audit Wales assured the group that Audit Wales are having periodic meetings with the Interim Executive Director of Finance and The Head of Internal Audit to keep abreast of any issues that could affect Audit this year.</p> <p><b>Action</b> – The Acting Board Secretary to reflect an item for All Wales Thematic on Workforce Planning Arrangements in the PPPH CoB.</p>	PM
<b>ITEMS FOR NOTING</b>	
<p><b>AC24.18 Briefings and update sessions (as appropriate)</b></p> <p>Nothing reported.</p>	

<b>CLOSING BUSINESS</b>	
<p><b>AC24.19 Summary of in Committee business to be reported in public</b></p> <p>AC24.19.1 The Acting Board Secretary noted details of breaches, financial performance, counter fraud progress report and how we report on how we engage internal Executive Director of Nursing and Midwifery</p>	
<p><b>AC24.20 Summary of Key Issues</b></p> <p>AC24.20.1 The following matters were discussed at the Audit Committee on 12 January 2024:</p> <ul style="list-style-type: none"> <li>• Terms of Reference were approved subject to some feedback from The Head of Internal Audit, in particular around making sure it is in line with the NHS Audit Wales Committee’s handbook.</li> <li>• Assurance around matters relating to Committee Governance and next steps for approval at Board.</li> <li>• Policy on Policies noted the Executive Team will be meeting w/c 15 January 2024 and the final document will be returning to Audit Committee in March for approval which needs to be reflected in the Special measures milestones and deadlines.</li> <li>• Details of breaches were reported which ongoing actions are still in place.</li> <li>• Declarations of interest, gifts and hospitality discussed and next steps are to make sure it is reported in a more granular way on bands of people who responded and this will be a standing item for the Corporate Governance report.</li> <li>• Ombudsman review noted the update and status of matters raised with the Ombudsman.</li> <li>• Risk Management noted updates on the CRR and BAF, generally good progress, however, more work to do in terms of RAG status.</li> <li>• Special Measures report noted good progress and the timelines on Policy on Policies may need to be adjusted.</li> <li>• Accounting progress and conformance reports to note in particular the approval of losses special payments.</li> <li>• Briefly spoke about Counter Fraud, however, the main report was discussed in the Private section of the meeting.</li> <li>• Internal Audit Tracker noted and right approach needed by the Executive Team accountability.</li> <li>• Internal Audit Progress report noted items reported on including deferral of the Wrexham Maelor.</li> <li>• Auditor Generals updates noted the work programme and allied CoB point.</li> </ul> <p><b>Action</b> – The Acting Board Secretary to work with the Audit Committee Chair, Interim Executive Director of Finance, Chief Executive and Internal</p>	<p>PM</p>

on the progress of the Audit Tracker report to provide assurances in future AC.	
<b>AC24.21 Items to Escalate to Board</b>  PM – Corporate governance arrangements progressing to Board, feedback around CRR and BAF reports	
<b>AC24.22 Date of Next Meeting</b> 15 March 2024	

DRAFT

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

	Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Revised timescale/ Action status (O/C)	RAG status
<b>Actions from 13 January 2023</b>						
1.	Acting Board Secretary	<b>Charitable Funds - AC23.08.5G</b> The role of the Charity would be discussed at the Audit Committee Workshop in May.	15-May-2023	This action remains outstanding due to the change in membership.  New date to be set.	Action outstanding  For update at the March 2023 Audit Committee.	
<b>Actions from 15 May 2023</b>						
1.	Executive Director of Finance	<b>Annual Report – AC23.62</b> The Executive Director of Finance to consider where the best place for the Board to consider the topic of sustainability.	15 Sep-2023	Until all Committees are re-established this work will be continued through the PFIG Committee	Sustainability to reside with the recently established Planning Population and Health Partnerships (PPPH) Committee - <b>Action closed. Remove from Action Log after March Audit Committee.</b>	
<b>Actions from 15 September 2023</b>						
6.	Acting Board Secretary	<b>AC23.86 Declarations of Interest/Gifts &amp; Hospitality</b> Implementation Plan Update on Declaration of Gifts and Hospitality - The Board Secretary to report back in	January 2024	Head of Corporate Affairs to develop implementation plan. AC provided with an update – Jan 2024.  A substantive agenda item will be produced for the May 2024 AC	05.03.24 Propose for closure.	

		January on progress and compliance.		and a brief update is provided (therein the March AC Corporate Governance report).		
10.	Acting Board Secretary	<b>AC23.93 National Audit Report for information</b> - The Acting Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising.	Nov 2023	Acting Board Secretary updated the Executive Team work plan - for inclusion by end of November 2023  05.03.24 Tabled at the Executive Team (ET) Meeting of the 13 March 2024. <i>Proposed for closure</i> – Acting Board Secretary to confirm item is agreed at ET.	13 March 2024	
<b>Actions from 16<sup>th</sup> November 2023</b>						
3.	Acting Board Secretary	The robustness of issues in relation to breaches of late publications to be reviewed by Head of Corporate Affairs taking into account Internal Audit's last report on breaches to work on strengthening the process.	Jan 2024	Breach paper produced for AC and process is being monitored for robustness.  29.02.24 Item remains on the agenda until stronger assurances are provided to the Committee.  05.03.24 The intervention orders issued to BCUHB upon entering into Special Measures did give a more lenient transition - as per Standing Orders, so breaches to date can mainly be marked as compliant.	Closure of this item is dependent upon the acceptance of the Corporate Governance Report on the 15 March 2024.	

Actions from 12 <sup>th</sup> January 2024						
1.	Interim Executive Director of Finance	<b>AC24.3.2</b> The Interim Executive Director of Finance agreed to attain Charitable Funds Articles of Association for review.	March 2024	Update to be provided.	To discuss action status on 15 March 2024.	
2.	Acting Board Secretary/Head of Internal Audit (HoIA)	<b>AC24.4.2</b> To ensure the Committee ToR are in line with the Model Terms of Reference. The HoIA advised he would provide details to the Interim Board Secretary in accordance with the timelines required for the next Health Board meeting.	March 2024	March 2024 - Action complete.	Propose for closure.	
3.	Acting Board Secretary	<b>AC24.4.3</b> The Health Board Chair provided feedback around the 'Committee Vice Chair' advising that the appointment nomination would be confirmed at the next Audit Committee.	March 2024	05.03.24 The Health Board has successfully appointed all IMs now and they commence on 1 March 2024. The Chair of the HB will communicate Committee appointments as soon as is practical.  Verbal update to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	
4.	Acting Board Secretary	<b>AC24.5.4</b> Declarations of Interest/Gifts & Hospitality Implementation Plan. The Acting Board Secretary would enhance future DOI updates <i>as discussed e.g per banding declarations.</i>	As per Cycle of Business.	Verbal update to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	

5.	Head of Risk Management	<b>AC24.8.5 &amp; .9</b> The Risk Register and Board Assurance Framework overviews are to provide more of a dashboard approach and a RAG status.	To be agreed.	Update to the action to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	
6.	Deputy Director of Workforce	<b>AC24.8</b> The Deputy Director of Workforce agreed to review and update the risk and additional detail pertaining to the programme of activity for the Leadership Team.	March 2024	04/03/24 - Item complete.  Revised report undergoing quality assurance by the Risk Management Team and will be submitted to the Risk Management Group and Executive Team - for scrutiny therein the onwards cycle of reporting.	May 24.	
7.	Acting Board Secretary	<b>AC24.9.2</b> The Acting Board Secretary to work with the Director of Transformation and Improvement to 'Update on milestones and arrangements related to the AC' report; <i>specifically</i> 21.9 policy arrangements and implementation - to note new timescales and the capturing of information.	March 2024	05.03.24 This has been updated in the Special Measures programme information	Proposed for closure.	
8.	Interim Executive Director of Finance	<b>AC24.11.5</b> Purchase Order breaches - the Committee Chair suggested that a deeper dive into the reasons for this be instigated.	To be agreed.	Update to the action to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	

9.	Interim Executive Director of Finance	<b>AC24.12.1</b> Key Assumptions and Judgements 23/24 Annual Accounts The detailed paper would be brought to the next Committee meeting.	March 2024	Agenda Item – March 2024	Agenda Item – propose to close.	
10.	Acting Board Secretary Head of Risk Management	<b>AC24.14.5</b> Internal and External Audit Tracker - The Chair noted that the timing of items presented for closure needed to be considered in light of Minute points: AC24.13.3 and 4. It was agreed that a discussion around this would take place before the next committee meeting.	March 2024	Update to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	
11.	Interim Executive Director of Finance	<b>AC24.16.1 &amp; 2</b> – Lessons Learnt ‘Make it safe reviews’ system.  The Interim Executive Director of Finance suggested the development be sighted in the Executive Team Meeting and that QSE has sight of the quality of the system.	March 2024	Update to the action to be provided at the 15 March Committee.	To discuss action status on 15 March 2024.	
12.	Acting board Secretary	<b>AC24.16.3</b> Acting Board Secretary to add <i>Decarbonisation</i> to the PPPH Committee Agenda.	March 2024	05.03.24 Suggest close, as PM contacted Chair of PPPH on 5 March 2024 to arrange.	Proposed for closure.	

13.	Acting Board Secretary	<b>AC24.17.2</b> The Acting Board Secretary to reflect an item relating to; All Wales Thematic, on Workforce Planning Arrangements in the PPPH CoB.	March 2024	05.03.24 Suggest close as PM contacted Chair of PPHP on 5 March 204	Proposed for closure.	
14.	Acting Board Secretary	<b>AC24.20.1</b> The Acting Board Secretary to work with the Committee Chair, Interim Executive Director of Finance, Chief Executive and Internal Audit on progress relating to the Audit Tracker report, to provide assurances in future AC.	March 2024	<p>05.03.24 There has been some significant work on this including the review of approach at the Executive Team Meeting following the last AC.</p> <p>A meeting is being arranged between the Executive Director of Operations and Audit Chair.</p> <p>A process developed <i>with IA agreement</i> on how to check completion. 04.03.24 IA report produced on closed recommendations to follow at May 2024 AC.</p>	<p>Item to be kept open (until AC Chair is assured).</p> <p>To discuss action status on 15 March 2024.</p>	

<b>Teitl adroddiad:</b> <i>Report title:</i>	Special Measures Update			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	15 <sup>th</sup> March 2024			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
<b>Argymhellion:</b> <i>Recommendations:</i>	The Committee is asked to <b>RECEIVE ASSURANCE</b> on the progress to date, acknowledging the challenges highlighted and risks to delivery.			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Carol Shillabeer, Chief Executive (Accountable Officer)  Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Geraint Parry, Special Measures Programme			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>  Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	To support Special Measures			
<b>Goblygiadau rheoleiddio a lleol:</b> <i>Regulatory and legal implications:</i>	Not applicable			

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

# Special Measure Update

---

## 1) Introduction

---

This report presents an update on Cycle 3 (December 2023 to February 2024) based on the latest proactive assurance assessments undertaken towards the end of February 2024. At the point of writing and submitting the report the formal closure assessment for Cycle 3 is underway and due to conclude by the middle of March. A full closure report will be circulated to all Board members following review at the Executive Team.

The report provides an assurance rating against individual milestones supported by narrative updates of progress to date and a proactive forward look to the end of the cycle in terms of delivery.

## 2) Progress to date

---

Overall, for those milestones within the Audit Committee remit, good progress has been made during the third cycle. At the time of writing, 7 milestones are already complete, and a further 8 are assessed as being on track with high confidence for completion by the end of the cycle.

There are 2 milestones where delivery is marked as amber because mitigations are required, to address delays within the cycle. An amber rating indicates that at present those mitigations have a reasonable prospect of course-correcting without significant over-run.

2 milestones are currently rated by the PMO as red; based upon updates received they are not likely to complete as planned by the end of the cycle.

## 3) Independent Reviews

---

With regards to the Independent Reviews pertaining to Audit Committee,

### **Review of the Office of the Board Secretary**

Following presentation of the management response during the Autumn, the action plan has been enacted and good progress has been made with more than three quarters already marked as complete. These continue to be factored into the wider oversight of themes coming out of all of the Special Measures Independent Reviews.

### **Stocktake Review of Progress against previous Mental Health Reviews**

The Health Board has received a draft copy of the review and has responded in terms of factual accuracy. The final report is expected during early March and plans will be made to bring this report to a development session when available. Consideration is being given to the elements of the review that are likely to pertain to safety and ensuring appropriate links with the QSE committee.

---

## 4) Recommendations

---

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the challenges highlighted and risks to delivery.

## Appendix 1 – Summary of Cycle 3 Milestones

### Key

Completed

On Track to deliver by end of Cycle

There are risks to delivery by end of Cycle

Will not deliver by end of Cycle

## 1. A well-functioning Board

Deliverable	Milestones summary text	SRO	Status	Due Date
C1-1.5: All committees with assigned IMs operational	1.5.7 Phase 2 - Approval at January Board of full and finalised Corporate Governance arrangements outlined in the OBS Review and highlighted below: 1. ToR for all Committees 2. Confirmed membership for each Committee 3. Cycle of Business for each Committee 4. Corporate Calendar for 2024/25	Phil Meakin	Completed	31/01/24
	1.5.8 Findings from the Independent Review reports available received by each of the relevant Board Sub Committees.	Phil Meakin	On Track to deliver by end of Cycle	29/02/24
	1.5.9 Committee Business Management Group (CBMG) re-introduced and scheduled to take place on a quarterly basis	Phil Meakin	Will not deliver by end of Cycle	29/02/24
	<b>PMO Assurance Comments:</b> The Terms of Reference for all Committees were all ratified at the January Board and the Corporate Calendar has now been agreed and distributed. All of the Independent Reviews received by the Health Board have been actioned accordingly, with Vascular being presented to a development session in December and the management response being prepared for formal QSE committee. Arrangements are underway for the Contract Procurement Management review to be brought to PFIG, and comments regarding factual accuracy for the Planning Review and Mental Health Stocktake were submitted on the 9th February, with arrangements for committees in hand. The re-introduction of the Committee Business Management Group will be deferred until a full set of Independent Members have been appointed.			
C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases	1.7.9 4x Permanent IMs recruitment: "Phase 3" job adverts closed	Phil Meakin	Completed	31/01/24
	1.7.10 Exec recruitment: Adverts live to close gaps in Executive Team where appropriate (dependent on Exec Portfolio Review and Senior HR Cases)	Jason Brannan	There are risks to delivery by end of Cycle	31/01/24
	<b>PMO Assurance Comments:</b> The adverts for the Independent Members have closed and the Minister has now announced the 4 appointments. Proposals on Executive Team roles, based on the Exec Portfolio Review, have been formulated and circulated for feedback by those impacted. This activity needs to conclude before all the relevant adverts for executive recruitment go live. The recruitment has completed for a Director of Corporate Governance with a start date of 1 <sup>st</sup> April, and the Executive Director of Workforce and OD advert is now live.			
C2-1.8: OBS team – implement interim and design permanent structure	1.8.5 Met necessary governance and achieved necessary sign offs to enable full implementation of OBS structure	Phil Meakin	On Track to deliver by end of Cycle	30/07/24
	1.8.6 Director of Corporate Governance recruitment: Interviews held (this appointment will enable the design and implementation of the permanent structure)	Phil Meakin	Completed	31/12/23
	1.8.7 Interim OBS structure agreed by CEO and Chair, and implementation has completed	Phil Meakin	Completed	31/01/24
	<b>PMO Assurance Comments:</b> The Interim structure for the Office of the Board secretary has been agreed and implemented and the new Director of Corporate Governance has been appointed with a start date of April 1st. The work around the permanent structure has been deferred until the post holder is in place.			

C2-1.9: Policy management and implementation/audit approach	1.9.3 A stock take of all policies will be undertaken and Exec Team members asked to prioritise the review of policies that they are responsible for.	Phil Meakin		31/01/24
	1.9.4 The final "Policy on Policies" document approved at Audit Committee in January 2024	Phil Meakin		31/01/24
	<b>PMO Assurance Comments:</b> The stock take of policies is complete and the Executive Team have reviewed during February. The final approval at Audit committee did not take place in January and will now be deferred until March which is outside of the cycle.			
C3-1.10: Progress implementation of the risk management framework	1.10.1 Risk Management Training reflecting the new Risk Management Framework design and tested	Phil Meakin		29/02/24
	1.10.2 Final format for the Board Assurance Framework agreed by Board Members (updated to include strategic objectives if available during Cycle 3)	Phil Meakin		29/02/24
	<b>PMO Assurance Comments:</b> The updated risk management training plan was approved at the Risk Management Group on the 6 <sup>th</sup> February and has now been submitted for translation before loading onto ESR. Further work around wider Risk Management Procedures requires sign-off from the Executive Team and is on track for the end of the cycle. A final format of the Board Assurance Framework was taken to the Board on 25th January with some minor modifications to be made before implementation.			
C3-1.11: Permanent IM/Exec recruitment – dependent Senior HR Cases	1.11.1 4x Permanent IMs recruitment: Interview dates set (WG lead this activity – Board Secretary will link in for feedback on progress)	Phil Meakin		31/01/24
	1.11.2 Progress design of the revisions to the Executive Portfolio through discussion and implementation/recruitment commenced	Phil Meakin		29/02/24
	<b>PMO Assurance Comments:</b> The interviews for the Independent Members took place on the 6th and 7th February and this is now marked as complete. With regards to Executive Portfolios, the proposed design and revisions paper was shared on 19th January with discussions scheduled and comments received by 1st February. In general, proposals were well received and plans for recruitment have commenced.			
C3-1.12: Implement phase 2 induction for all Board members	1.12.1 Induction for Vice chair and x2 IMs recruited in November 2023 completed, using new Board Induction Programme	Phil Meakin		31/12/23
	<b>PMO Assurance Comments:</b> The Board Induction Handbook and SharePoint have been finalised and the Vice Chair and 2 IMs recruited in November 2023 have been completing their induction using the new Board Induction Programme.			
C3-1.13: Develop phase 2 Board development programme	1.13.1 Phase 2 Board Development programme for 2024/25 reviewed at Executive Team	Phil Meakin		31/01/24
	1.13.2 Phase 2 Board Development programme for 2024/25 agreed with the chair through engagement with board members	Phil Meakin		29/02/24
	<b>PMO Assurance Comments:</b> The Phase 2 Board Development Programme is being finalised and the CEO has confirmed arrangements for Executive team members to review. The Chair will then undertake subsequent engagement with Board members.			

## 4. Improved access, outcomes and experience for citizens

C1-4.6: Mental Health review of previous reviews – phase 2	4.6.7 Copy of Royal College of Psychiatry MH&LD report received.	Teresa Owen		31/01/24
	4.6.8 MH&LD/RCPsych Action Plan developed and scheduled for sign off via appropriate governance routes.	Teresa Owen		29/02/24
<p><b>PMO Assurance Comments:</b>  A copy of the report has been received in draft form and response provided to Welsh Government re: factual accuracy. The final report is expected during March and the resulting action plan will be developed and taken through Audit Committee governance.</p>				

<b>Teitl adroddiad:</b> <i>Report title:</i>	Risk Management Board Assurance Framework and Corporate Risk Register		
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee		
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Friday, 15 March 2024		
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this standing agenda item is to provide a Chair's assurance summary from Risk Management Group and an update position of the Corporate Risk Register and Board Assurance Framework risks.</p> <p>Partial assurance is noted as Committees are yet to receive 8 further corporate risks to which they have overall accountability for. The report contains details of these and well as updates on changes.</p> <p>1-Summary Assurance of Risk Management Group</p> <p>2-Board Assurance Framework changes to note (Appendix 1):</p> <ul style="list-style-type: none"> <li>• Prevention and Health Protection BAF score change 15&gt;12</li> <li>• Women's BAF score change 16&gt;12</li> <li>• Quality, Innovation and Improvement BAF score change 25&gt;20</li> </ul> <p>3-Corporate Risk Register (Appendix 2):</p> <ul style="list-style-type: none"> <li>• Dashboard including specific highlights on progress and Full Corporate Risk Register is attached.</li> </ul>		
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to note and <b>receive assurance</b> for:</p> <ul style="list-style-type: none"> <li>• Chair's Assurance Report from the Risk Management Group (full assurance)</li> <li>• Board Assurance Framework (full assurance)</li> <li>• Corporate Risk Register (partial assurance).</li> </ul>		
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Phil Meakin, Acting Board Secretary		
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Nesta Collingridge, Head of Risk Management		
<b>Pwrpas yr adroddiad:</b>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>

<b>Purpose of report:</b>				
<b>Lefel sicrwydd:</b> <b>Assurance level:</b>	<b>Arwyddocaol</b> <b>Significant</b> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <b>Acceptable</b> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <b>Partial</b> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <b>No Assurance</b> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b> 1-BAF risks to be reviewed and aligned to Health Board Objectives 2-Corporate Risk register-some risks remain in draft from October 2023 and yet to be presented to Committees  <b>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:N/A</b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>		Links to the BAF detailed in respective CRR reports		
<b>Link to Strategic Objective(s):</b>				
<b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b>		It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.		
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b>		N/A		
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</b>		N/A		
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b> <b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>		Links to the BAF detailed in respective CRR reports		
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <b>Financial implications as a result of implementing the recommendations</b>		The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered		

	to our patients thus leading to enhanced quality, less waste and no claims.
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>  <b>Workforce implications as a result of implementing the recommendations</b>	N/A
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>  <b>Feedback, response, and follow up summary following consultation</b>	Risks approved by Executives as the lead for the risk, Risk Management Group 06/02/24 Executive Team on the 14/02/24, QSE 20/02/24 and PFIG 22/02/2024.
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	BAF paper which further links Tier 1 and CRR.
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	N/A
<b>Camau Nesaf:</b>  <b>Next Steps:</b> <ol style="list-style-type: none"> <li>1. Strategic Training for Executive Team/Board Members</li> <li>2. Outstanding Corporate Risks to be completed ahead of April Risk Management Group</li> </ol>	
<b>Rhestr o Atodiadau:</b>  <b>List of Appendices:</b> <ol style="list-style-type: none"> <li>1. Board Assurance Framework Updates (3)</li> <li>2. Corporate Risk Register (not including private ICT Failure &amp; Cyber Risk reviewed at PFIG)</li> </ol>	

## 1. Introduction and Background

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

Where Board Assurance Framework risks are deemed to be high or extreme (above a risk score of 15) a risk report is produced for the Committee that has oversight of those risks.

Table 1 & 2 below highlight a summary of risks.

Appendix 1-2 contains detailed information, including controls/mitigations and action plans to address the risk.

## 1.2 Key Considerations for this Committee

The dashboards for each respective risk register highlight changes to three BAF scores.

The number of corporate risks still in development (8) was escalated to Risk Management Group, the Executive Team and reported as partial assurance to the respective committees. Audit Committee can be assured that the risks which remain to be in development and subsequently yet to be approved by Executive Team. A completion date of 28 February 2024 has been set for this work to be completed and all 8 risks have now been drafted and will be included in the next iteration of papers.

## 1.3 Risk Updates from Board Assurance Framework

Table 1 highlights three BAF risks have been approved by the Executive Team for being moderated down:

**SP1- Prevention and Health Protection-** Progress is delayed but most actions now completed. Score revised now from 15 to 12, so no longer a high risk and can be reviewed for closure from the Board Assurance Framework (scores 15>).

**SP9- Women's Services-** remains to have an 'Amber' Delivery Confidence with multiple proposed delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red. Progress is delayed but most operational actions now completed. Score revised now from 16 to 12, as likelihood is now a 3 so no longer a high risk and can be reviewed for closure from the Board Assurance Framework (scores 15>).

**SP18-Quality Innovation and Improvement** -Score reduced from 25 to 20 as there are still several actions delayed but delivery confidence is now positive.

## 1.4 Corporate Risk Register

The Corporate Risk Register Dashboard (Table 2). No movements in scores have been made as the majority of actions are not yet due which will further reduce the score. The committee is asked to note the current cycle of receiving updates is underway and an indication of changes is highlighted to committee. As of the next meeting, this cycle of reporting will now be in line and the committee will see those changes that have been approved at Risk Management Group and the Executive Team Meeting in future reports.

In future iterations of the corporate risk dashboard the committee will be provided with an update of those actions/target dates which have been completed or are overdue/revised as well as changes in score.

## 2. Summary of RMG on 6 Feb 2024

The Risk Management Group (RMG) convened on the 06/02/2024. The group reviewed and **approved an updated cycle of business**, adding a risk performance report as a standing agenda item going forward.

- **The Risk Management Training Plan was approved** and further endorsed at the Executive Meeting for approval on the 14/02/2024
- The Q3 Risk Performance Report was received, providing an overview of risk management metrics and highlighting improvement opportunities.

The Q3 quarterly Performance and Assurance report provides visibility of risk themes and trends across BCUHB regions and services from October to December 2023.

- Minor increase in overall risks compared to previous quarter, demonstrating generally steady risk reporting. Majority of risks remain medium to high.
- Central region reports risks most frequently, East second most, and West reports the least frequently. Fewer risks reported in West may be due to consolidating risks.
- Increase in pan-BCUHB risks reported - 60% of risks added this period were pan-BCUHB. 30% of pan risks do not have a host assigned.
- Significant number (281) of Non-live risks which need to be progressed to Live and active management.
- Notable underreporting in Finance, Workforce, Primary Care, Office of Allied Health Professionals and Therapies and Communications team. These services require focused engagement to strengthen risk management.
- Decrease in closure rates compared to previous quarter. Ongoing monitoring and support needed to improve closure of risks.
- Quality assurance shows risks largely managed sufficiently but some lack timely reviews, unrealistic targets set, outdated action plans, inconsistent scoring.

Recommendations were made which will be added to the Corporate Risk Management Workplan:

- Support services to identify hosts for pan-BCUHB risks.
- Prioritise reducing overdue non-live risks.
- Promote closure through training and oversight of unimpactful action plans.
- Address underreporting services through focused engagement.
- Triangulate performance and planning weaknesses with risk identification.
- Embed risk review in local governance meetings, utilising risk leads.
- Ongoing monitoring, mitigation and closure of risks is advised, alongside delivery of risk management training plan to drive improvement.
- The Board Assurance Framework and Corporate Risk Register reports were presented to the group. Both documents reflect the current key risks and controls from a strategic perspective. The number of corporate risks outstanding were escalated to the group and agreed to be escalated to the Executive Team.

- Regarding risk escalations, 50 risks were escalated as high risks. These aligned with existing organisational risk themes and corporate risks. A theme of medication-related risks was noted, which is being reviewed by the Chief Pharmacist. 20 Tier 1 risks were de-escalated to Tier 2 or closed.
- An overview of risk discussions at recent Executive Team and Board meetings was provided.
- Updated risk registers received from Workforce & Organisational Development, Transformation & Planning, the North Wales Medical School, and Medical Director's Office.
- Workforce outlined plans for regular risk register reviews and conducting a gap analysis as they recognised possible underreporting, (presented in the performance report).
- The Head of Health and Safety continued by raising concerns in relation to IHC representation and limitations due to structural changes impacting on the Strategic Occupational Health & Safety Group. An updated Health and Safety risk register was requested for the following meeting.

### **3.0 Board Assurance Framework & Corporate Risk Register**

3.1 TABLE 1 – Board Assurance Framework Dashboard

3.2 TABLE 2 – Corporate Risk Register Dashboard

Appendix 1 Board Assurance Framework updates (3 reports)






Appendix 2 Corporate Risk Register (Full, excluding Private Risk)

### 3.1 TABLE 1 – Board Assurance Framework Dashboard

Title	Executive	Score	Revision	Annual Plan Analysis	Risk Management Commentary
<b>Executive Team approved changes</b>					
Strategic Priority P1 Prevention and Health Protection	Executive Director of Public Health	12	↓	Overall 'Amber' Delivery Confidence With 2 priorities delayed from Q3 to Q4 (23/24). <b>6 actions completed</b> , 2 Amber, 1 Red.	Risk score moderated down from <b>15 to 12</b> as most actions completed.
Strategic Priority P9 Women's Services	Executive Director of Operations	12	↓	Overall 'Amber' Delivery Confidence With delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red.	Likelihood reduced from 4 to 3 as confidence has increased and several operational risks now completed changing the overall score from a <b>16 to a 12</b> .
Strategic Priority P18 Quality, Innovation and Improvement	Executive Director of Nursing and Midwifery	20	↓	Overall 'Green' Delivery Confidence with 1 action delayed from Q3 to Q4 (23/24). 0 actions completed, 0 amber, 0 red. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed."	Risk score has subsequently been reduced from <b>25 to 20</b> . Reconsider impact of 5 in following iteration of report and provide rationale if remains.

\*BAF Templates to be updated by leads following conversation with Planning Team and Corporate Risk Team prior to Risk Management Group 9<sup>th</sup> April

Title	Score	Revision	Annual Plan Analysis	Risk Management Commentary
Strategic Priority P2 Primary Care	9	↑	Overall 'Amber' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1 (24/25) and 1 priority delayed from Q4 to Q1 (24/25). 0 actions completed, 2 Amber, 2 Red.	Risk score should be reviewed and possibly may increase.
Strategic Priority P3 Planned Care	25	↓	Overall 'Green' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25). 1 action completed, 0 Amber, 0 Red.	Risk score to potentially be moderated down if confidence is positive.
Strategic Priority P5 Cancer	20	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q3 to Q1 (24/25). 3 actions completed, 2 Amber, 0 Red.	Delivery Confidence to be monitored, risk has been updated
Strategic Priority P4 Urgent and Emergency Care	TBC	-	Overall 'Green' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1/Q4 (23/24). 2 actions completed, 0 Amber, 0 Red.	-
Strategic Priority P10 Children	20	↓	Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q3 (24/25). 0 actions completed, 0 Amber, 0 Red.	Score to potentially be moderated down if confidence is positive.
Strategic Priority P11 Wider Delivery	TBC	↑	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red.	Assessment of the risk score should be completed

Strategic Priority P12 Workforce	12		Overall 'Green' Delivery Confidence With all on track. 4 actions completed, 0 Amber, 0 Red.	Risk score to potentially be moderated down if confidence is positive.
Strategic Priority P13 Digital, Data and Technology	20	- 	Overall 'Amber' Delivery Confidence With multiple priorities having red or amber delivery confidence. 5 actions completed, 4 Amber, 3 Red.	To remain
Strategic Priority P14 Estates and Capital	TBC		Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 7 actions completed, 7 Amber, 0 Red.	Risk in draft by the service
Strategic Priority P15 Partnerships	9	-	Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 9 actions completed, 3 Amber, 0 Red.	To remain as a low risk as several actions completed.
Strategic Priority P16 Board leadership and governance	16		Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q4 (23/24). 0 actions completed, 0 Amber, 0 Red.	Risk score to potentially be moderated down if confidence is positive.
Strategic Priority P17 Organisational development	12		Overall 'Amber' Delivery Confidence With 1 priority delayed from Q4 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red.	Risk score should be reviewed and possibly may increase.

### 3.2 TABLE 2 - Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type	Lead Board Committee	Head of Risk Management Comments
					Appetite Level		
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ↔	8	People 4 - Seek	P&C	New risk as of Dec 23. 8 Actions identified, 6 due end of Feb 24. Update required on the progression of these actions as it should reduce by March 24 as per target date. Progress update planned 04/03/24 in line with cycle of reporting to Risk Management Group and Executive Team meeting.
EDoN	CRR24-02	Patient Safety-Falls	5 x 4 = 20 ↔	12	Quality 3 - Open	QSE	Escalated from operational risk as of Dec 23. Inherent and current score of 20, further controls to be reviewed to reduce current score. 3 actions due to be completed in Dec 23 and 3 in Jan 24, progress update completed and revisions have been made to the action plan dates, and will be reported in line with cycle of reporting. Likely revision of target date to be anticipated. RMG discussed the possibility for this risk to encompass other significant high risk patient factors (deterioration and pressure ulcers) which will also be reviewed.
EDoN	CRR24-03	Safeguarding	4 x 4 = 16 ↔	12	Quality 3 - Open	QSE	5 Actions due in March all progressing well confidence is high that this will reduce the score of the likelihood down to 3 but yet to be approved formally and will be discussed in the next cycle of reporting to the Executive Team.
EDoN	CRR24-04	Failure to Embed Learning	4 x 5 = 20 ↔	5	Reputational 4 - Seek	QSE	New CR as of Dec 23, 7 actions identified 6 are due in March 2024. Controls further refined following Executive Team review 17/01/23 but action plan progress will be updated in the next cycle. The first action will be delayed due to reliance on NHS Executive National team. Actions 6 and 7 are being merged and revised date of May for Board approval and will be updated.
EDoF	CRR24-05	Financial Sustainability	5 x 4 = 20 ↔	12	Financial 2 – Cautious	PFIG	Action plan developed, risk score has remained at 20 since opened in March 2023. Score and action plan reviewed and discussed at RMG and PFIG.
EDoF	CRR24-06	Suitability and Safety of Sites	TBA	TBA	Quality 3 – Open	PFIG	Risk now approved by Executive and will be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.

CDIO	CRR24-07	Availability and Integrity of Patient Information	5 x 4 = 20 ↔	12	Quality	PFIG	New Risk, 7 actions identified and 6 due in March 24. Discussed at PFIG for further strengthening cost implications of implementing ICO recommendations.
					3 - Open		
EDoPH	CRR24-08	Population Health	5 x 4 = 20 ↔	12	Reputational	PPPH (QSE)	<b>Inherent and current score of 20</b> , further controls to be considered to reduce current score. Target date 2026 (could have annual interim targets and actions to demonstrate movement).
					4 - Seek		
EDoO	CRR24-09	Community Care and Primary Provision	TBA	TBA	Quality	QSE	(TBA- To be Approved) Risk waiting approval by Executive to be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					3 - Open		
EDoO	CRR24-10	Urgent and Emergency Care	TBA	TBA	Quality	PFIG	Risk waiting approval by Executive to be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					3 - Open		
EDoO	CRR24-11	Planned Care	TBA	TBA	Quality	PFIG	Risk waiting approval by Executive to be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					3 - Open		
EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	TBA	TBA	Quality	QSE	Risk waiting approval by Executive to be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					3 - Open		
EDoTH	CRR24-13	Timely Diagnostics	TBA	TBA	Reputational	QSE	Risk now approved by Executive and will be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					4 - Seek		

EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	TBA	TBA	Quality	QSE	Risk developed and to be submitted to Executive for approval, to be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					3 – Open		
EDoW	CRR24-15	Health and Safety	TBA	TBA	People	P&C	Risk to be approved by Executive and will be included in the next round of meeting cycles for approval at Risk Management Group and the Executive Team meeting.
					4 – Seek		
EDoW	CRR24-16	Leadership/Special Measures	4 x 4 = 16	8	Regulatory	P&C	New risk. Controls further refined following Executive Team review 17/01/23. ¼ Actions complete, actions to be further developed to reduce the score. Comments noted by the lead from AC in January 2024 and risk will be strengthened, Progress update planned 04/03/24 in line with cycle of reporting to Risk Management Group and Executive Team meeting.
					3 - Open		
CDIO	CRR24-17	ICT Failure and Cyber	4 x 5 = 20	15	Reputational	PFIG	New Risk, 'dependent on funding' noted on target date, 2026, (further treatments to be identified). Target score of 15. Action plan discussed at PFIG.
					4 - Seek		

**Lead Board/Committee Key:**

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

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

Trend	
No trend/Score remains the same	
Increase	
Decreased	

## Appendix 1 BAF Detailed Information

### BAF Reports for Review and highlighted updates

BAF Prevention and Health Protection	<b>Executive:</b> Executive Director of Public Health		<b>Date Opened:</b> March 2023			
	<b>Committee:</b> PPPH (Quality, Safety and Experience Committee)		<b>Date Last Reviewed:</b> 8 <sup>th</sup> February 2024			
	<b>Strategic Priority:</b> SP1	<b>Link to CRR:</b> Population Health		<b>Committee Review Date:</b> 20/02/2024		
		<b>Link to Tier 1's:</b> 4200/4201/1642		<b>Target Risk Date:</b> 31 March 2024		
There is a risk that the Health Board fails to adequately plan for and deliver improvement of population health and reduce health inequalities. This may be caused by a lack of provision for sustainable services and targetted programmes of activity, and capacity, financial and resource constraints within the Health Board. This may contribute to poorer health outcomes and widening inequalities alongside increasing demand on services across North Wales.						
<b>Mitigations/Controls in place</b>		<b>Gaps in Controls</b>		<b>Current Risk Score</b>		
1. Population Health Exec Delivery Group (PHEDG) provides strategic direction and monitors delivery of the Population Health Services. 2. There are a number of key strategy documents specific to local needs developed with partners e.g. including weight, smoking, infant feeding, mental health and wellbeing, immunisations and reducing alcohol intake. 4. Integrated Health Community plans reflect local priorities based on data and evidence. 5. Population Needs assessment informs local planning. 6. Progress reports to Public Health Wales (PHW) in regard to activity funded by PHW and links to national programmes of work. 7. Progress reports to Arts Council of Wales in regard to activity funded by Arts Council. 8. Building a Healthier North Wales Partner Network meets three times per year to share learning and develop network. 9. Engagement and contribution to Regional Partnership Group. 10. Engagement and contribution to Public Services Boards. 11. Strategic partnership with Actif North Wales. 12. Regular meetings with Welsh Government in relation to Prevention and Early Years funded activity. 13. <a href="#">The Deputy Director of Public Health commenced in post (October 2023)</a> 14. <a href="#">The Strategic Partnership Manager commenced in the seconded post (October 2023)</a>		1. In order to implement a system wide approach, it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. 2. Inadequate resources and multiple constraints including finance. 3. System wide change cannot be implemented within 1-3 years as is well documented through evidence and research. 4. Prevention, health inequalities, improving health and wellbeing should be strengthened through integration into all planning and decision making frameworks, with sufficient weighting. 5. Robust intelligence and data availability at local level to support planning and decision making 6. <a href="#">Executive Director of Public Health tenders notice to step down.</a> 7. <a href="#">Public Health funding provided by the Health Board is subject to RIGA which would have consequences on several programmes of work in 24/25.</a>		Impact	Likelihood	Score
				4	3	12
				Quarter 3 activity: 1. <a href="#">Help Me Quit Services are operational and have delivered the Tier 1 performance target.</a> 2. <a href="#">Whilst there has been much activity both within the health board and with our partners, the recruitment to Smoke Free Environment Officers has been paused given the financial position within the Health Board for 23/24. This will be reviewed in line with any confirmed Prevention and Early Years funding made available by Welsh Government for 24/25 alongside the Public Health priorities and associated work plan.</a> 3. <a href="#">Best Start area of BCUHB webpages (Preconception, Pregnancy, Early Years and Family) completely refreshed with almost 60 new pages developed in partnership with professionals, including new Preconception pages.</a> 4. <a href="#">Good progress against the Healthy Schools grant funded plan with confirmed funding for 24/25</a> 5. <a href="#">The Arts in Health Strategic Approach (3 years) was launched with partners in December 2023.</a> 6. <a href="#">Arts in Health Projects are underway with a focus on Ty Llewelyn and Neuro-diverse children and progressing to plan with reporting to the funding organisation (Arts Council Wales and Baring Foundation).</a> 7. <a href="#">ICL Programme continues progression within the constraints of financial position which has led to some of the initial deliverables within the business case being reviewed and revised. During Q3 ICL multi agency workshops took place across each of the local authorities as per the programme plan, with high profile attendees (Board members, Senedd members, Local Authority and Third Sector Board members).</a> 8. <a href="#">Autumn 23/24 COVID Vaccination Programmes are on track to complete in line with National Direction which closes on the 31st March 2024. The main delivery phase of the COVID vaccination</a>		

		programme is now complete, The Welsh average for delivery is 58.2% of the targeted cohorts, BCUHB is the 2nd best performing Health Board with 59.9% of eligible citizens vaccinated, only behind Powys.
<b>Actions and Due Date</b>		
Continue to deliver in year actions which support the All Wales Tobacco Control plan including smoke free regulations		
Continue to deliver in year actions which support the All Wales Weight Management Pathway		
Commence implementation of the in year actions from the Arts in Health 3 year Strategic Plan 31 <sup>st</sup> March 2024		
Continue to implement the in year actions from the Infant Feeding Strategic plan		
Share report and recommendations for service provision following Gypsy Roma Traveller needs analysis 31 <sup>st</sup> March 2024		
Together with partners and as part of the work of the Area Planning Board, implement the in year actions which support the Alcohol Strategy for North Wales 31 <sup>st</sup> March 2024		
<b>Lines of Defence</b>		<b>Overall Assessment</b>
<b>1</b>	<b>2</b>	<b>3</b>
1. Local Public Health Team 2. Public Health Performance and Risk Management Group 3. Population Health Executive Delivery Group 4. Public Health Consultants attend Integrated Health Community Senior Meetings	1. QSE Board 2. PPPH Committee	1. Internal Audit
Impact reduced from 5 to 4 meaning Score of 12, multiple constraints including finance, impacting on risk of deliverables identified in the annual plan and failure to meet adequate levels of delivery across a range of targeted prevention and health improvement activities.		

BAF SP9	<b>Executive:</b> Executive Director Operations	<b>Date Opened:</b> October 2023
	<b>Committee:</b> Partnerships, People and Population Health Committee	<b>Date Last Reviewed:</b> 8 <sup>th</sup> February 2024
	<b>Strategic Priority:</b> Women's	<b>Last Date Reviewed at Committee:</b> 22/02/2024
	<b>Link to CRR:</b> Staffing/Financial Sustainability <b>Link to Tier 1's:</b> 4490/ 4773	<b>Target Risk Date:</b> April 2024

There is a risk of failing to effectively implement critical actions to improve maternity, neonatal, and women's health services and outcomes.

Mitigations / Controls in place	Gaps in Controls	Current Risk Score		
		Impact	Likelihood	Score
<ol style="list-style-type: none"> <li>Local Maternity and Neonatal Strategic Plan mapping exercise of the National programme and recommendations has been undertaken to identify actions and resource requirements against 31 'short-term' maternity actions and 6 'short-term' neonatal actions.</li> <li>On-going engagement with Welsh Government (WG). NHS Executive commissioned to undertake Phase 2 (implementation) of the Maternity and Neonatal Safety Support Programme. The network will be providing the clinical and management leadership on the design and delivery of the Programme.</li> <li>Maternity and Neonatal Safety Support Programme actions have been included in the Women's Service Delivery Plan 23/24 under Transforming Maternity Services (Priority 1). Progress is monitored quarterly and reported to the Women's Transformation Group and Women's Service Delivery Board and upwardly via lines of defence. <a href="#">Any outstanding will translate to 24/25 Service Delivery Plan</a></li> <li>Digital Maternity Cymru National Programme Board established with appropriate BCUHB representation.</li> <li>Local Digital Maternity Cymru working group established ahead of the required governance structure for the implementation of the Maternity Information System.</li> <li><a href="#">Digital Health and Care Wales (DHCW) have confirmed Health Board funding has for 24/25 to support the Clinical Maternity Informaticist Lead (Band 8a) and Project Manager (Band 7) to support the national programme team</a></li> <li><a href="#">Service is planning for pre-implementation phase and required resource for this phase will be submitted as an Informatics Capital and Resource requirement.in Q4 24/25 In relation to the Quality Statement Women's, this is a Corporate Strategic Action for all Services led by the Health Board which will be supported by Women's Services. The service continue to develop the WG funded projects e.g. pelvic health and endometriosis services.</a></li> </ol>	<ol style="list-style-type: none"> <li>Awaiting clarification from the Welsh Government as to how the NHS Executive will manage Phase 2/ Implementation of the project and actual recommendations/ actions required for implementation by Health Boards. This has resulted in a significant delay in clarification for Health Boards and Service provider. <a href="#">In addition to the 134 recommendations the NHS Executive identified 3 priorities for action to be progressed during the transition phase (up to end March 2024 – on track to deliver in Q4 23/24). These include ATAIN, MEWOS Chart and PeriPrem Passport. All actions in progress no risks Delivery of National Digital Maternity Cymru Programme delayed. Likely implementation is Q4 24/25.</a></li> <li>No confirmed funding for Maternity and Neonatal Safety Support Programme implementation phase and recommendations.</li> <li>Funding for the local Informatics capital and resource requirements for Digital Maternity Cymru Programme not confirmed.</li> <li>No nationally confirmed funding for implementation of the system as confirmed at the DMC National Project Board on 8/2/24.</li> <li>Quality Statement for Women and Girls' Health - Confirmation of Corporate Executive Lead required. Also awaiting further National steer on prioritisation of the 10-year Women's Plan. <a href="#">No funding confirmed to date.</a></li> </ol>	4	3	12
		Movement since last Qtr: <a href="#">Likelihood reduced from 4 to 3 changing the overall score from a 16 to a 12. Action plan below 1 out of 5 completed with several short-term operational actions completed, 2 further controls added.</a>		

Actions and Due Date			
Action Detail			Due Date
Digital Midwife appointed to interface with the Digital Health Care Wales National team and local support for the pre-implementation planning.			Completed
Remaining Maternity and Neonatal Strategic Plan outstanding actions will be rolled over into 24/25 Women's Service Delivery Plan – implementation resource impact has been considered as part of the planning for 24/25.			March 2024
Clarification from WG as to how the NHS Executive will manage Phase 2 Implementation and prioritisation of the recommendations – update received see above.			March 2024
Local Capital and Resource requirements for Digital Maternity Cymru to be included in 24/25 planning to inform 25/26.			March 2024
Quality Statement for Women and Girls' Health (issued by WG). NHS Executive commissioned to lead on the development of a National Women's Health Network and 10-year Women's service plan. An Executive lead will need to be identified to locally lead on the Plan.			March 2024
Lines of Defence			Overall Assessment
1	2	3	
<ul style="list-style-type: none"> <li>1. Women's QSE</li> <li>2. Women's Risk Management Group</li> <li>3. Women's Integrated Performance Group</li> <li>4. Women's Senior Leadership Team meeting</li> <li>5. Women's Service Delivery Board</li> <li>6. Women's Transformation Delivery Group</li> </ul>	<ul style="list-style-type: none"> <li>1. BCUHB Quality Executive Delivery Group</li> <li>2. QSE Committee</li> <li>3. Executive Accountability Meetings</li> </ul>	<ul style="list-style-type: none"> <li>1. Welsh Government Digital Cymru Programme Board</li> <li>2. National Maternity and Neonatal Safety Support Programme Board</li> <li>3. IQPD</li> </ul>	<p>Further steer is required from NHS Executive (delegated by WG) in relation to the Maternity and Neonatal Safety Support Programme on prioritisation of recommendations made in the Discovery Phase. Local funding to deliver the priorities is to be confirmed.</p> <p>Short-term actions as detailed in the Maternity and Neonatal Safety Support Programme are progressing well within target and 15 green, 7 amber, and 9 on red. Delivery of the short term Maternity (6-12 months) have been included in the 23/24 Women's Service Delivery Plan and will translate into the 24/25 plan.</p> <p>Further steer is required from NHS Executive (delegated by WG) in relation to the Quality Statement for Women and Girls' Health, development of the National Women's Health Network and Women's 10 Year Service Plan. <a href="#">BCUHB Executive Lead also needs to be identified.</a></p>

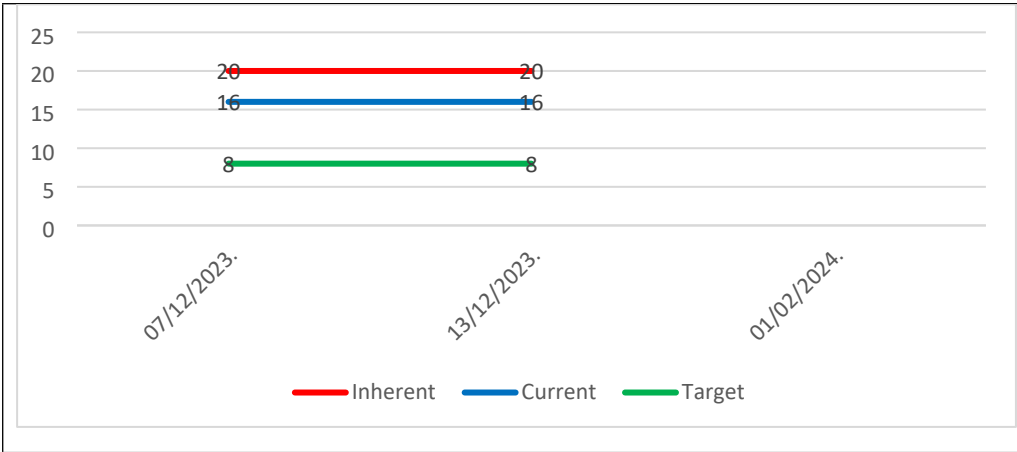
BAF SP18	<b>Executive:</b> Executive Director of Nursing and Midwifery		<b>Date Opened:</b> 19/10/2023				
	<b>Committee:</b> QSE		<b>Date Last Reviewed:</b> 8 <sup>th</sup> February 2024				
	<b>Strategic Priority: SP18</b> Quality, Innovation and Improvement	<b>Link to CRR:</b> Failure to Embed Learning <b>Link to Tier 1's:</b> 3025/4519/ 4520/3795/3759	<b>Last Date Reviewed at Committee:</b> 20/02/2024				
			<b>Target Risk Date:</b> April 2024				
There is a risk of failing to effectively strengthen governance arrangements following special measures and implement robust quality governance, improve organisational learning, and improve the handling of incidents, inquests, claims, mortality reviews and complaints.							
<b>Mitigations/Controls in place</b>		<b>Gaps in Controls</b>		<b>Current Risk Score</b>			
<i>These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.</i>		1. Need to develop a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement		Impact			
1. Putting Things Right and clinical review processes and monitoring		2. Need for clarity on quality leadership, structures and accountabilities		Likelihood			
2. Risk management processes		3. Need to review the quality governance framework of meetings and reporting		Score			
3. Audit programmes & monitoring arrangements		4. Need to develop a quality learning framework, aligned to the overall learning organisation programme		5			
4. Patient and carer feedback and involvement processes		5. Need to review Putting Things Right and clinical review processes and monitoring		4			
5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints		6. Need for resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests		20			
6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems		Movement since last Qtr: Score moderated from 25 to 20. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed target date changed from March 2024 to April 2024.					
7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation							
8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act							
9. Ward accreditation schemes and ward manager/matron checks/audits.							
10. Tracking of regulatory action plans							
11. Internal Reviews against External National Reports							
12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans							
13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings							
<b>Actions and Due Date</b>							
<b>Action Detail</b>					<b>Due Date</b>		
1. The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository.					March 2024		
2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.					March 2024		

3.	A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data.		December 2023
4.	A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning.		March 2024
5.	The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed.		March 2024
6.	The new Quality Strategy will be developed through a co-design process.		March 2024
7.	A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system.		March 2024
<b>Lines of Defence</b>			<b>Overall Assessment</b>
<b>1</b>	<b>2</b>	<b>3</b>	Target date revised from March to April 2024. Impact of 5 to be reviewed in following report.
1. Service and IHC Quality Groups 2. Putting Things Right and clinical review processes and monitoring 3. Ward accreditation schemes and ward manager/matron checks/audits 4. Organisational Learning Forum 5. Quality systems – RLDatix, Greatix, Civica Experience and AMAT	1. Quality, Safety and Experience Committee oversight of quality issues 2. Quality reporting to Board 3. Executive performance reviews with IHCs 4. Clinical audit 5. Patient and Carer Experience Group and oversight/assurance reporting 6. Patient Safety Group and oversight/assurance reporting 7. Clinical Effectiveness Group and oversight/assurance reporting 8. Regulatory Assurance Group and oversight/assurance reporting 9. 7. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report	1. Internal audit 2. HSE inspections 3. HIW/CIW inspections 4. PSOW investigations 5. WG performance monitoring and assurance 6. Welsh Government Reviews 7. Royal College Reviews	

## Appendix 2 Corporate Risk Register

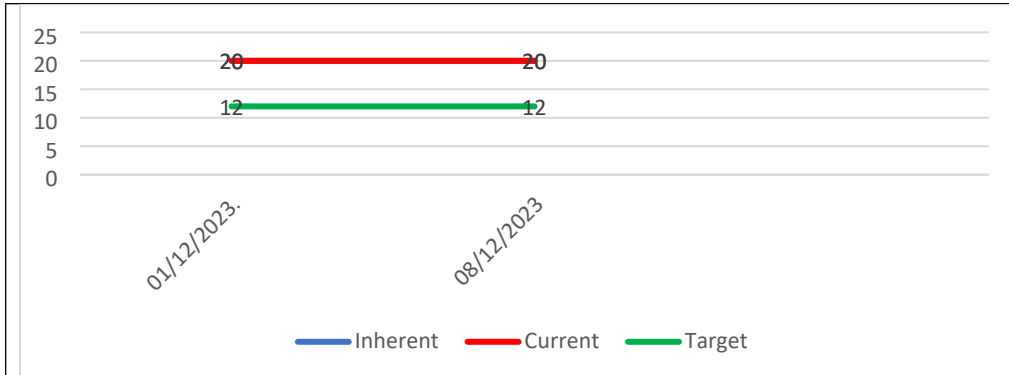
CRR 24-01	<b>Risk Title:</b> People, Culture and Wellbeing			<b>Date Opened:</b> 07/12/2023
	<b>Assuring Committee:</b> P&C (Performance, Finance and Information Governance Committee)			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Deputy Director of Workforce	<b>Link to Datix IDs</b>	1976/4431/4432/3947/4726 4939/2758/4564/4669/4285/4671	<b>Date Last Committee Review:</b> 20/02/2024
		<b>Link to BAF</b>	SP12	<b>Target Risk Date:</b> 31/03/2024
There is a risk that BCU do not have a <b>highly skilled</b> , engaged and <b>motivated</b> workforce which could impact on safe delivery of care. This could be caused by <b>staffing shortfalls</b> , organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.				
Controls in place		Assurances	Additional Controls required	Actions and Due Date
<ol style="list-style-type: none"> <li>1. People Committee is being scheduled to oversee delivery of the People Services agenda</li> <li>2. Education and Learning Committee is being established</li> <li>3. Local IHC &amp; Pan Services People &amp; Culture Committees in place</li> <li>4. The Strategic Recruitment team in place deliver timely campaigns for all senior leadership and medical &amp; dental appointments</li> <li>5. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities.</li> <li>6. The Recruiting well and Joining Well programmes are up and running</li> <li>7. Nursing Optimisation team leading on the Nurse retention programme</li> <li>8. A new Nurse Retention Lead post is at recruitment stage</li> <li>9. Flexible working policy has been updated and a new All Wales policy is due in Q4</li> <li>10. Staff feedback mechanism via the NHS Wales Staff Survey and ongoing pulse surveys</li> <li>11. Speak out Safely MDT in place</li> <li>12. Work in Confidence platform for staff to safely raise concerns</li> </ol>		<ol style="list-style-type: none"> <li>1. High risks, linked to CRR24-01 are reviewed and monitored via the People Committee, the Culture Steering Group and the People Services Senior Leadership Team.</li> <li>2. Progress towards the People Service agenda is reported through the People &amp; Culture Committee chaired by the CEO and reported to the Board.</li> <li>3. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board</li> </ol>	<ol style="list-style-type: none"> <li>1. The programme of work through the Education and Learning Committee to be finalised</li> <li>2. Increased measures on employee engagement</li> <li>3. A New proposal on the line manager's impact on employee engagement</li> </ol>	<p>The strategic actions relating to this CRR recorded in the special measures cycle 3 milestones are;</p> <ol style="list-style-type: none"> <li>1. Scoping and methodology proposal for the wider review of the 2022 Operating Model restructure agreed at Executive team following appropriate engagement; 31/12/2023</li> <li>2. Findings from the wider review of the 2022 Operating Model restructure presented to Execs Team and next steps agreed; 29/02/2024</li> <li>3. Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles 29/02/24</li> <li>4. Measure employee engagement: Proposal on a broad range of mechanisms to do this other than just the staff survey presented to Executive Team 29/02/24</li> </ol>

			<p>5. Formal Culture Change Plan and accompanying Comms and Engagement plan presented to Exec Team prior to scheduling for review at Board 29/02/24</p> <p>6. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan 29/02/24</p> <p>7. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board 29/02/24</p> <p>8. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts. This will enable improvements in a wide range of organisational outcomes, such as quality, access, experience 29/02/24</p>																				
	<table border="1"> <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>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">low level</td> <td>1-8</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	4	5	20	Current Risk Rating	4	4	16	Target Risk Score	2	4	8	Risk Appetite	low level		1-8		
	Impact	Likelihood	Score																				
Inherent Risk Rating	4	5	20																				
Current Risk Rating	4	4	16																				
Target Risk Score	2	4	8																				
Risk Appetite	low level		1-8																				
<b>Overall Assessment</b>																							



Newly developed risk, action plan to be reviewed end of March as per target date to reduce the score.

CRR 24-02	<b>Patient Safety - Falls</b>			<b>Date Opened:</b> 01/12/2023		
	Assuring Committee: Quality, Safety and Experience Committee			<b>Date Last Reviewed:</b> 14/02/24		
	Director Lead: Executive Director of Nursing and Midwifery	Link to Datix IDs	4748/3869/3893/4562		<b>Date Last Committee Review:</b> 20/02/2024	
		Link to BAF	N/A		<b>Target Risk Date:</b> 01/02/2024	
There is a risk to patient safety, in particular harm, as a result of slips, trips and falls within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as <b>reduced staffing</b> , segregated areas and <b>premises</b> which do not allow for ease of oversight, compliance with <b>manual handling training</b> , compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.						
<b>Controls in place</b>		<b>Assurances</b>	<b>Additional Controls required</b>		<b>Actions and Due Date</b>	
<p>1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%.</p> <p>2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months.</p> <p>3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager.</p> <p>4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards:</p> <p>5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards.</p> <p>6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.</p> <p>6. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete.</p>		<p>1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group.</p> <p>2. Ward accreditation metrics</p> <p>3. Ward accreditation review process</p> <p>4. Peer reviews</p>	<p>1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group.</p> <p>2. Assurance and training of agency workers.</p> <p>3. Improved compliance with manual handling training.</p> <p>4. Sustained improvement in the quality of completion of FBHMA.</p>		<p>1. New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched 30/12/2023. - Completed</p> <p>2. Audit of Ward Managers induction checklist for agency staff to ensure falls training has been completed 13/12/2023.</p> <p>3. Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce 01/01/2024.</p> <p>4. Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity by December 2023. 30/12/2023.</p> <p>5. Outcome of peer review pilot to be evaluated and recommendation presented to the Strategic Inpatient Falls Group for sustainable model 01/02/2024.</p> <p>6. The Welsh Nursing Care Record currently does not auto populate with Patient details such as mobility status from the admission assessment section into the FBHMA. This will be a future enhancement to the Welsh Nursing Care Record on an all-Wales basis. 01/02/2024.</p>	
				Impact	Likelihood	Score
Inherent Risk Rating				4	5	20



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

Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
<b>Overall Assessment</b>			

1 out of 6 actions have been completed, 2 to be progressed in Dec and remaining actions to be completed by February 2024 in order to reduce this score down to the target of 12. This is in line with the Falls Internal Audit limited assurance report. The Falls Group also have oversight of the gaps in controls and is working to mitigate these. Further work required on current score and controls to reduce the risk score.

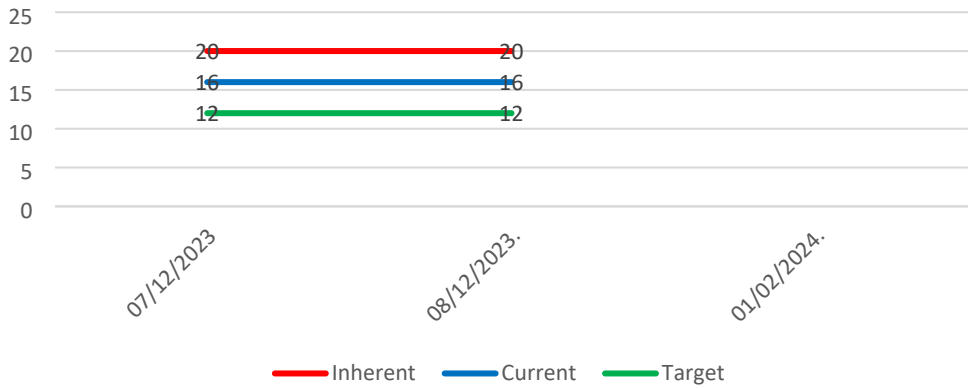
CRR 24-03	<b>Safeguarding</b>			<b>Date Opened:</b> 07/12/2023
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Executive Director of Nursing and Midwifery	<b>Link to Datix IDs</b>	<b>3766/2548</b>	<b>Date Last Committee Review:</b> 20/02/2024
		<b>Link to BAF</b>	<b>N/A</b>	<b>Target Risk Date:</b> 31/03/2025

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

<b>Controls in place</b>	<b>Assurances</b>	<b>Additional Controls required</b>	<b>Actions and Due Date</b>
<p>1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks.</p> <p>2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework.</p> <p>3. BCUHB mandatory safeguarding training is in place for all staff.</p> <p>4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds.</p> <p>5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government.</p> <p>6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC).</p> <p>7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.</p>	<p>1. The risks is monitored monthly and reviewed at the Safeguarding Governance and Performance Group and scrutinised at QSE/RMG.</p> <p>2. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government.</p> <p>3. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board.</p> <p>4. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.</p>	<p>1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control.</p> <p>2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions.</p> <p>3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance.</p> <p>4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings.</p> <p>There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. <del>The team and service is experiencing a high sickness position. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.</del> <b>The Reduced leadership team capacity due to absences.</b></p> <p>5. There is a lack of governance and reporting of</p>	<p>1. The Ockenden Review (2018) Recommendation 6 recorded that for an organisation such as BCUHB a significant amount of work was still needed to be done to strengthen safeguarding services. A review of the safeguarding team and structure is underway. Action Due 31/03/24</p> <p>2. National development and implementation of Single Unified Safeguarding Review. Action Due 31/03/25</p> <p>3. Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Section 5 Allegations or Concerns about Practitioners and Those in Positions of Trust. Action Due 31/03/24</p> <p>4. North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications. Action Due 31/03/24</p> <p>5. Development of a DoLS/CoP DoL Standard Operating Protocol (SoP) for assessing existing BCUHB funded patients in community settings and for assessing future funded patients. Action due 31/03/24</p>

Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.

6. CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration. 30/03/2024  
 7. Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices.



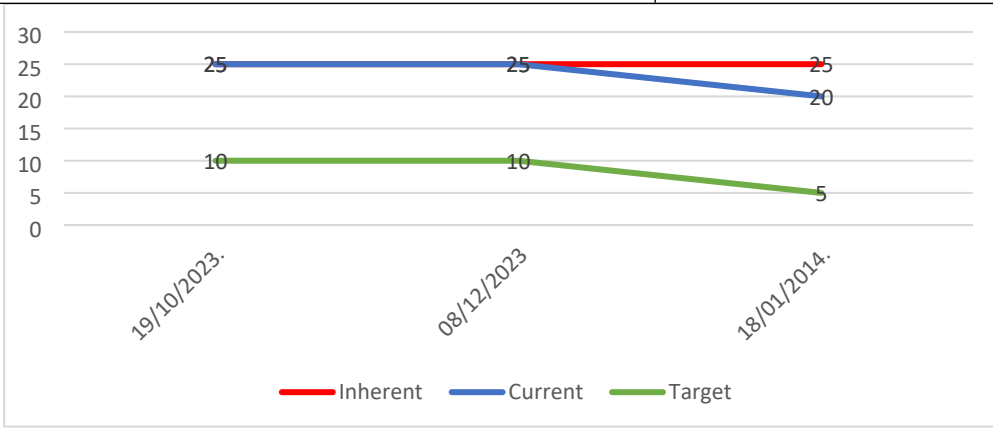
	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8

**Overall Assessment**

Action Plan now progressing well in line with Target and a revised likelihood of 3 will be presented to Risk Management Group.

CRR 24-04	<b>Failure to Embed Learning</b>		<b>Date Opened:</b> 19/10/2023
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b>	<b>Link to Datix IDs:</b> 3025/4519/4520/3795/ 3759	<b>Date Last Committee Review:</b> 20/02/2024
	Executive Director of Nursing and Midwifery	<b>Link to BAF:</b> SP18 - Quality, Innovation and Improvement	<b>Target Risk Date:</b> March 2024
There is a risk that the Health Board could fail to meet requirements for <b>timely review and learning</b> from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.			
<b>Controls in place</b>	<b>Assurances</b>	<b>Additional Controls required</b>	<b>Actions and Due Date</b>
<ol style="list-style-type: none"> <li>1. Putting Things Right and clinical review processes and monitoring</li> <li>2. Risk management processes</li> <li>3. Audit programmes &amp; monitoring arrangements</li> <li>4. Patient and carer feedback and involvement processes</li> <li>5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints</li> <li>6. Clinical policies, procedures, guidelines, pathways, supporting documentation &amp; IT systems</li> <li>7. Clinical staff recruitment, induction, mandatory and professional training, registration &amp; re-validation</li> <li>8. Defined nurse staffing levels for all wards &amp; departments as per Nurse Staffing Act</li> <li>9. Ward accreditation schemes and ward manager/matron checks/audits.</li> <li>10. Tracking of regulatory action plans</li> <li>11. Internal Reviews against External National Reports</li> <li>12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans</li> <li>13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings</li> </ol>	<ol style="list-style-type: none"> <li>1. Service and IHC Quality Groups (with reporting)</li> <li>2. Quality Delivery Group, its sub-groups (with reporting) and the Quality, Safety and Experience Committee oversight of quality issues</li> <li>3. Quality reporting to Board</li> <li>4. Executive performance reviews with IHCs</li> <li>5. Clinical audit and Internal audit</li> <li>6. Regulatory Assurance Group and oversight/assurance reporting</li> <li>7. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report</li> <li>8. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW</li> <li>9. WG performance monitoring and assurance</li> <li>10. Welsh Government Reviews</li> <li>11. Royal College Reviews</li> </ol>	<ol style="list-style-type: none"> <li>1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement</li> <li>2. Clarity on quality leadership, structures and accountabilities</li> <li>3. Review of the quality governance framework of meetings and reporting</li> <li>4. Development of a quality learning framework, aligned to the overall learning organisation programme</li> <li>5. Review of Putting Things Right and clinical review processes and monitoring</li> <li>6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests</li> </ol>	<ol style="list-style-type: none"> <li>1. The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository. – March 2024</li> <li>2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements. – March 2024</li> <li>3. A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data. – December 2023</li> <li>4. A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. – March 2024.</li> </ol>

- 5. The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed. – March 2024
- 6. The new Quality Strategy will be developed through a co-design process. – March 2024
- 7. A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system. – March 2024

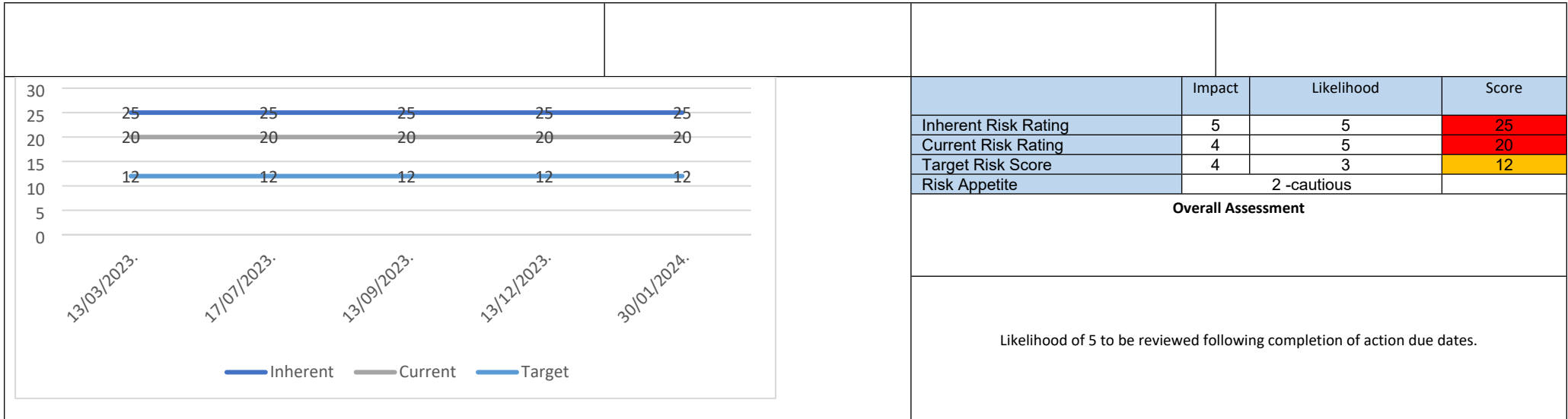


	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	low level		1-8

**Overall Assessment**

Delays in actions noted by lead and risk will be updated to reflect position in the next cycle of reporting.

CRR 24-05	<b>Risk Title:</b> 2023/24 Financial Plan			<b>Date Opened:</b> 13/03/2023
	<b>Assuring Committee:</b> Performance, Finance and Information Governance Committee			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Executive Director of Finance	<b>Link to Datix IDs</b>	4861/4862	<b>Date Last Committee Review:</b> 22/02/2024
		<b>Link to BAF</b>	N/A	<b>Target Risk Date:</b> 31/03/2024
<p>Failure to achieve the Annual Plan for 2023/24 (£134.2m deficit), due to non-delivery of planned level of financial improvement</p> <p>The financial plan for 2023-24 has identified a forecast deficit of £134.2m. This includes a target for financial improvement of £38.7m, which is based on the following:</p> <ul style="list-style-type: none"> <li>Disinvestment identified £13.5m</li> <li>Savings Target £25.2m (Stretch Target £30m)</li> </ul> <p>Failure to deliver the target for financial improvement could adversely impact on the achievement of the financial plan and increase the deficit.</p>				
<b>Controls in place</b>	<b>Assurances</b>	<b>Additional Controls required-</b>	<b>Actions and Due Date</b>	
<ol style="list-style-type: none"> <li>Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions has been agreed to meet at senior leadership team SLT and performance to be challenged at EDIPG.</li> <li>Cross cutting themes with Executive leadership have also been agreed to support IHC/other delivery.</li> <li>Introduction of the Recurrent Investment Group Assurance (RIGA) to assess the £100m Annual Plan investment (Phase 1).</li> <li>Introduction of the Establish Control Group to review all requests for A&amp;C posts and all Band 7+ posts (Non-Patient Facing) and to obtain Executive approval before advertising and reduction of Interim Corporate Staff from 52 to 7.</li> <li>Internal reporting by Department on a monthly basis including review of overspends and forecasts.</li> <li>Financial reporting to Welsh Government on a monthly basis, with the MMR.</li> <li>Financial (including Savings and Finance Special Measures Action Plan) oversight arrangements in place through the Performance, Finance and Information Governance Committee (PFIG)</li> <li>Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent rather than non-recurrent.</li> <li>Additional £101m (£76m conditionally recurrent) provided by Welsh Government, reducing the deficit from £134m to £33m at Month 7.</li> <li>Standing Financial Instructions updated to reflect the model issued by Welsh Government and Scheme of Reservation and Delegation (SoRD) strengthened.</li> </ol>	<ol style="list-style-type: none"> <li>EDIPG</li> <li>Executive Team</li> <li>Performance, Finance and Information Governance Committee /Audit Committee</li> <li>Board Committee</li> <li>External</li> </ol>	<p><b>Gaps</b></p> <ol style="list-style-type: none"> <li>Welsh Government expectation to achieve a control total deficit of £20m. Delivery of control target may result in the £82m previous WG funding support plus the new 23/24 £76m investment, becoming recurrent funding in 2024/25.</li> </ol>	<ol style="list-style-type: none"> <li>Recurrent Investment Group Assurance (RIGA) to assess the £42m Investments Plan (Phase 2). <b>Due Date: 29/2/24</b></li> <li>Application of Control Totals to Divisions to reduce expenditure by 2% between November and March 24.  M9 Year to date deficit above plan reduced to £19.4m (an improvement of £6.3m).  M9 Savings Plans £25.2m Recurring Target. £18.5m Recurring Green Plans (£25.6m R and N/R). £19.6m Recurring Forecast Delivery (£28.6m R and NR Forecast Delivery). In addition, non budget releasing mitigating actions (AGs £5.3m to date, £0.749m run rate reductions and £3.1m ECG Savings).  <b>Due Date:31/3/24</b></li> </ol>	



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	2 -cautious		

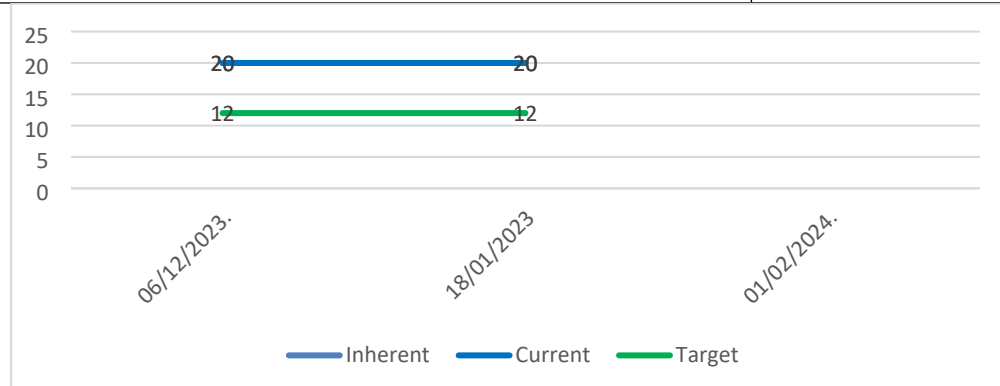
**Overall Assessment**

Likelihood of 5 to be reviewed following completion of action due dates.

CRR 24-07	<b>Risk Title:</b> Availability and Integrity of Patient Information			<b>Date Opened:</b> 06/12/2023
	<b>Assuring Committee:</b> Partnerships, People and Population Health Committee			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Chief Digital and Information Officer	<b>Link to Datix IDs</b>	2819/4594/3659/4603/4766/4576 4420/4604/4902/4981	<b>Date Last Committee Review:</b> 22/02/2024
	<b>Link to BAF</b>	SP13	<b>Target Risk Date:</b> April 25	

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

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1. Digital, Data and Technology Strategy in place to set the direction and vision for digital integration, with regular reporting to, Partnerships, People and Population Health Committee. 2. Current paper file identified as the Master Copy of the full record. 3. Access to current clinical systems to print clinical information ready to store in the Master File. 4. Contract in place with third party supplier who are ISO accredited to scan directly into CiTO and destroy clinical paper records confidentially.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Information Governance Toolkit embedded with operational group oversight and monitoring. 3. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee. 4. Internal Audit Annual Information Governance Compliance Audit. 5. Information Commissioners Office Audit.		1. Establish the cost and resource requirements to back scan all live records 2. Undertake a review of national systems to ensure these can be integrated into the CiTO system – April 2025



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

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	low level		1-8

**Overall Assessment**

Newly developed risk to be further developed and reviewed

CRR 24-08	<b>Risk Title: Population Health</b>			<b>Date Opened:</b> November 2023
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Acting Executive Director of Public Health	<b>Link to Datix IDs</b>	1642/4200/4201	<b>Last Committee Review:</b> 20/02/2024
		<b>Link to BAF</b>	SP1	<b>Target Risk Date :</b> March 2026

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

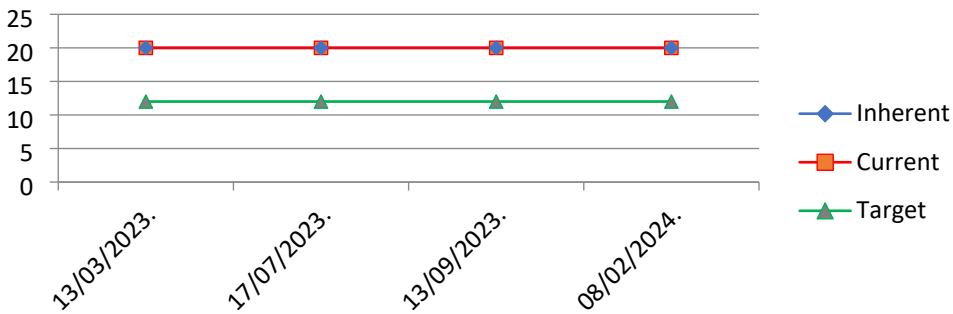
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic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

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

Controls in place	Assurances	Gaps in Controls	Actions and Due Date
<ol style="list-style-type: none"> <li>Population Health Executive Delivery Group (meets monthly) provides strategic direction.</li> <li>PPPH Committed has oversight and received regular reports.</li> <li>Welsh Government provides oversight of grant funded activity supporting prevention and early years.</li> <li>The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Public Health Team. <a href="#">The Deputy Director of Public Health is currently Acting Executive Director of Public Health.</a></li> <li>Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise.</li> <li>Public Health Team provide review and feedback on planning applications.</li> <li>Health Protection Team work in partnership with Local Authorities to provide expertise and management of cases.</li> </ol>	<ol style="list-style-type: none"> <li>Risks linked to CRR24-09 are reviewed and monitored via the Population Health Executive Delivery Group and the Public Health Senior Leadership Team.</li> <li>Health Board progress is reported to Regional Partnership Board and PPPH Committee.</li> <li>The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing.</li> <li>The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans.</li> <li>Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted.</li> <li>Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums.</li> <li>A 'Whole System Approach' is being implemented across a number of key priority areas.</li> <li>A number of national programmes of work are underway including implementing the Weight Management Pathway and Smoke Free Sites regulations.</li> <li>Annual development of Public Health work plan to reflect current and emerging need.</li> <li>National Performance Framework measures.</li> </ol>	<ol style="list-style-type: none"> <li>In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals.</li> <li>The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increasing the activities required.</li> <li>It is acknowledged that this is a long term risk which cannot be mitigated and fully evidenced within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success.</li> <li>Investment in prevention within the health board through investment of core funding.</li> <li>Commitment from partners within the health board area to population health and prevention activity due to financial and capacity constraints</li> <li>The failure to recognise the risk associated with the demographic profile and current</li> </ol>	<p>Actions supporting mitigation of this risk are via delivery of a range of specific strategies, plans and frameworks (some of which are continuous by nature of the work) which include:</p> <ol style="list-style-type: none"> <li>Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan</li> <li>All Wales Weight Management Pathway 2021</li> <li>Infant Feeding Strategy 2019 (current refresh underway to 2025)</li> <li>Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways)</li> <li>Together for Mental Health Strategy (local / national)</li> <li>Well North Wales targeted partner programmes</li> <li>Health Board Annual Plan / 3 year milestones and associated activity</li> <li>Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases</li> <li>Immunisation Strategy 2023-2026</li> </ol>

- 11. The Health Protection Team have established funding in 24/25 Health Board allocation.
- 12. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects

- prevalence of chronic conditions and how further demand due to a lack of prevention could risk overwhelming the system in the future.
- 7. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale.
  - 8. The current cost of living crisis will adversely affect those most at risk.
  - 9. The current financial position of the Health Board and its partners will impact on investment into key business cases which support this work.
  - 10. The current position of the Health Board within escalatory measures and short term focus to meet ministerial and special measures priority actions may reduce focus on longer term priority work.
  - 11. The availability of data to support strategic focus at the local level and planning is not available.
  - 12. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.



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

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
<b>Overall Assessment</b>			

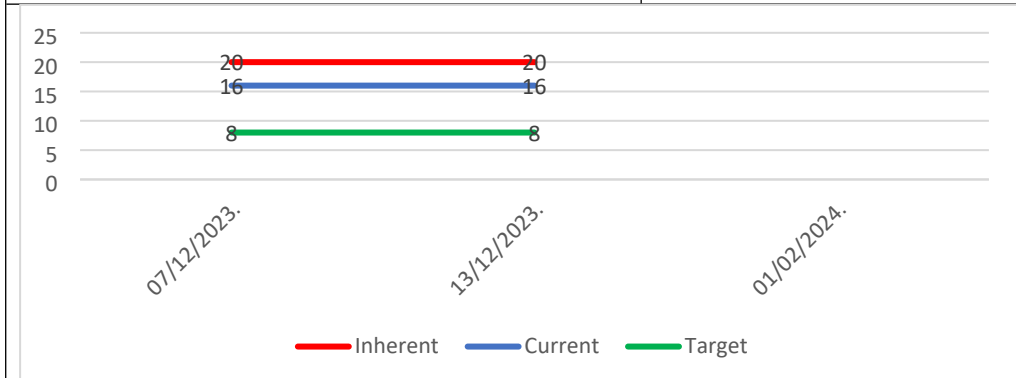
Action plan requires dates and inherent score to be reviewed.

CRR 24-16	<b>Leadership/Special Measures</b>			<b>Date Opened:</b> 07/12/2023
	<b>Assuring Committee:</b> People and Culture Committee			<b>Date Last Reviewed:</b> 14/02/24
	<b>Director Lead:</b> Deputy Director of Workforce	<b>Link to Datix IDs</b>	<b>4480/3969</b>	<b>Date Last Committee Review:</b> 12/01/2024 (Audit Committee) due to be received at P&C
		<b>Link to BAF</b>	<b>SP17</b>	<b>Target Risk Date:</b> 31/03/2024

There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.

Controls in place	Assurances	Additional Controls required	Actions and Due Date
<ol style="list-style-type: none"> <li>1. People Committee is being scheduled to oversee delivery of the People Services agenda</li> <li>2. Culture Change Steering Group will be reporting into Board via the CEO report</li> <li>3. Local Integrated Health Communities &amp; Pan Services People &amp; Culture Committees</li> <li>4. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement underway.</li> </ol>	<ol style="list-style-type: none"> <li>1. Risks linked to CRR24-16 are reviewed and monitored via the People Committee, the Culture Steering Group and the People Services Senior Leadership Team.</li> <li>2. Health Board progress reported through the People Committee to the Board and through the CEO report to the Board.</li> <li>3. Work associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board</li> </ol>	<ol style="list-style-type: none"> <li>1. Integrated Leadership Development Framework</li> <li>2. New approach to leadership and how to adopt it, aligned with the work on values and behaviours</li> <li>3. Formal Culture Change Plan and accompanying Comms and Engagement plan</li> <li>4. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan</li> <li>5. Revisit the values of the organisation</li> <li>6. Develop a behaviours framework</li> <li>7. Identification of resources to deliver the Culture Change programme</li> </ol>	<p>The strategic actions relating to this CRR recorded in the special measures cycle 3 milestones are;</p> <p>Integrated Leadership Development Framework socialised across the organisation for feedback 31/01/2024</p> <p>Integrated Leadership Development Framework implementation plan presented to Executive Team 29/02/2024</p> <p>Exploration of approach to leadership: Draft proposal of the approach and how to adopt it, aligned with the work on values and behaviours, presented to Executive Team prior to scheduling for review at Board 29/02/2024</p> <p>OD Steering Group established 30/12/2023</p>

--	--	--	--



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8

**Overall Assessment**

--



<b>Teitl adroddiad:</b>	<b>Corporate Governance Report for Audit Committee</b>			
<b>Report title:</b>				
<b>Adrodd i:</b>	Audit Committee			
<b>Report to:</b>				
<b>Dyddiad y Cyfarfod:</b>	Friday, 15 March 2024			
<b>Date of Meeting:</b>				
<b>Crynodeb Gweithredol:</b>	The purpose of this report is to provide Audit Committee with assurance on Corporate Governance matters in 1 report. This includes			
<b>Executive Summary:</b>	<ul style="list-style-type: none"> <li>• Details of Breaches related to production of Board and Committee papers</li> <li>• Policy on Policies</li> <li>• Update on Review of Gifts &amp; Hospitality and Dol Registers</li> </ul>			
<b>Argymhellion:</b>	<i>The Committee is asked to:</i>			
<b>Recommendations:</b>	<ul style="list-style-type: none"> <li>• <b>Note</b> the report on breaches to Board and Committee agenda and papers</li> <li>• <b>Note and Approve</b> the “Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents”</li> <li>• <b>Note</b> the progress being made on updating policies</li> <li>• <b>Note</b> the update on Declarations of Interest and Gifts and Hospitality</li> </ul>			
<b>Arweinydd Gweithredol:</b>	Phil Meakin - Acting Board Secretary			
<b>Executive Lead:</b>				
<b>Awdur yr Adroddiad:</b>	Phil Meakin – Acting Board Secretary			
<b>Report Authors:</b>	Supported by: <ul style="list-style-type: none"> <li>• Philippa Peake-Jones – Head of Corporate Affairs</li> <li>• Jody Evans – Corporate Governance Officer</li> </ul>			
<b>Pwrpas yr adroddiad:</b>	I’w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Purpose of report:</b>				
<b>Lefel sicrwydd:</b>	Arwyddocaol <i>Significant</i> <input type="checkbox"/>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>
<b>Assurance level:</b>	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing</i>	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence /</i>	Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>

	<i>mechanisms/objectives</i>	<i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<i>evidence in delivery of existing mechanisms / objectives</i>	
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>		<p>This work links to all strategic objectives of the Health Board as corporate Governance is a key enabler for them.</p>		
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>		<p>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.</p> <p>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.</p>		
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b></p>		<p>This is not applicable for this report.</p>		
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>		<p>This is not applicable for this report.</p>		
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p>		<p>Internal controls such as the Policy on Policies are fundamental to compliance. A failure to implement a robust policy for the development and review of written control documents may leave the organisation exposed to the following risks:</p> <ul style="list-style-type: none"> <li>• Failure to provide employees/workers with comprehensive, up to date guidance may result in the application of inappropriate care or care that is not in line with current best practice. This in turn could lead to harm being incurred by patients and subsequently, financial detriment via the redress process.</li> <li>• Failure to provide employees/workers with comprehensive, up to date guidance may</li> </ul>		

	<p>result in non-compliance with non-clinical legislative obligations / public sector duties, which could incur financial penalty via fines.</p> <ul style="list-style-type: none"> <li>• Failure to provide an authoritative repository may result in employees/workers having limited confidence that the document they require is extant or fit for purpose. Employees/workers should be able to efficiently access a single, authoritative source where they can easily navigate to the appropriate guidance and have confidence that the document that they are applying is correct, without fear of legal or professional repercussions.</li> <li>• Failure to provide adequate guidance may result in complications during disciplinary proceedings. Written control documents enable BCUHB to set out the standards required. If employees/workers do not comply with the relevant written control document, then this may be justification for invoking the relevant disciplinary and/or capability procedure.</li> <li>• Failure to provide an authoritative Policy on Policies may result in written control documents being developed without the appropriate oversight, consultation or approval which may lead to variances in care across the BCUHB sites.</li> <li>• When incidents/concerns do occur or arise, professional regulators or members of the public may request the document in force at the time. BCUHB risk further reputational damage or regulatory enforcement action wherein the document cannot be found, is out of date or not fit for purpose</li> </ul>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The effective and management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to have effective Corporate Governance can impact adversely on the workforce.</p> <p>The development of robust Policies and Declarations of Interest as outlined in this report will strengthen arrangements for workforce related matters</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>This report now reflects the additional consultation that has been received and has been shared with the Executive Team for further comments in relation to Policies</p>

<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	BAF Risk Board Leadership and Governance
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	Not applicable
<b>Next Steps:</b>  If approved the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents <ul style="list-style-type: none"> <li>• will be communicated to the organisation and information provided to Services and Corporate Functions setting out requirements.</li> <li>• To schedule an update at the next Audit Committee (May 2024) on the programme to update policies</li> </ul> To bring a full report on Declarations of Interest and Gifts and Hospitality to the next Audit Committee in May 2024	
<b>List of Appendices:</b>  Appendix 1 - Summary of Breaches Appendix 2 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents  <a href="#">Link to the untracked version of the Policy document here</a> – (should you wish to view the tracked changes and comments following consultation).	

## Corporate Governance Report for Audit Committee

### **1. Introduction and Background**

- 1.1. The objective of this report is to give the Audit Committee an update on key Corporate Governance matters in the following areas.
- Details of Breaches to Publication of Board and Committee Papers
  - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents
  - Brief update on Review of Gifts & Hospitality and Declarations of Interest Registers

### **2. Breaches – Publication of Board and Committee Agenda and Reports**

- 2.1 This is a routine agenda item now for every Audit Committee to demonstrate improvement in this facet of Governance. The most recent update is provided in Appendix 1. Three breaches were recorded since the last Audit Committee and clarification on how to log any breaches has been shared with those working on Board Meeting and Committee business. The Committee should note that there were no breaches in February to report on.
- 2.2 As agreed at the last Audit Committee a summary table will be produced that illustrates monthly trends related to breaches and this will be reported from May 2024.
- 2.3 It should be noted that when the Health Board was placed under Special Measures the Welsh Ministers initiated “subordinate legislation” called the “Betsi Cadwaladr University Health Board Intervention (Amendment) Order 2023. It did, in principle allow Board papers to made available, “where reasonably practicable, at least five clear days before the meeting.” This is not the standard that the Health Board wishes to operate at so it is proposed to continue to report on breaches to seven clear days before the meeting.
- 2.4 Given the information above it is considered as providing “acceptable assurance” to the Audit Committee and this should be further evidenced by the May 2024 report.

### **3. Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents**

- 3.1 The Audit Committee is asked to approve this Policy and also note next steps on the development of policies that are past a review date with a proposal to bring an update on this to the May Audit Committee. The Draft Policy for approval is in Appendix 2 (in the appendix section of the cover sheet). There is also a tracked change version should Committee members wish to see the detail. Table 1 and 2 below summarise the amendments.
- 3.2 The Health Board has a duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislation, enabling all employees/workers to fulfil their roles safely and competently. The Health Board’s Policy on Policies sets out the various roles, responsibilities and the route to be followed when developing or updating written control documents. *There is a Special Measures Milestone 1.9.4 “The final Policy on Policies document approved at Audit Committee in January 2024”*

3.3 The Policy on Policies was originally developed in 2018 and was due for review in 2021. The revised Policy on Policies is appended at Appendix 2. The Policy was discussed by the Executive Team on the 30/08/2023. The amendments and proposed approval route were agreed in principle and had been subject to a review at the Audit Committee held on 15/09/2023 and an update brief at Audit Committee on 12/01/2024.

3.4 The main changes following this review **had been as follows in Table 1 below**

**Table 1 – Amendments to Draft “Policy on Policies” following Initial Consultation**

- A proposed new approvals route. Previously, any pan BCUHB policy required final approval at the relevant Board level Committee. The revised approval route delegates this responsibility to the relevant Executive (noting that some policies, as per the Health Board Standing Orders, are reserved for Board approval) [14].
- ‘Scope’ section strengthened to ensure the policy captures all workers (i.e. interim/agency) [5.1].
- Clarity provided as to the definition of a ‘local document’ [5.3]
- ‘Document outside the Scope’ section added to provide clarity on the management of Patient Group Directions, Pathways and Patient Information [7.3].
- ‘Impact Assessments’ section revised to make reference to the newly developed BCUHB Integrated Assessment Screening Tool [11].

3.5 **Following the review at the Audit Committee held on the 15/09/2023 the Policy was then subject to further organisational Consultation** – feedback incorporated into the draft Policy that is in Appendix 2. This additional time allowed feedback to be noted and received via Pharmacy Leads, ICU – Anaesthetics Lead and Womens Services and Deputy Director of Quality.

3.6 The Draft policy has been amended and shared with the Executive Team in advance of it being received at Audit Committee. Table 2 below shows the amendments that have been received in this further consultation.

**Table 2 – Amendments following additional consultation**

- Page 19 table 2 –
  - Prescription chart approvals
  - Reference to BRAG/Shared Care Documentation
- 14.3 Updated to reflect Medicines related guidance and approvals.
- Supplementary Guidance - Updated to confirm Strategic approval details.
- Policy Template – Updated with Corporate Formatting requirements (Contents table, titles and reference / version control section.
- Document Submission Form – Updated and irrelevant sections removed.
- 5.3 - Local documents’ further defined, and explicit governance/approval expectations described. This includes the new IHC structure and CEG.
- 14.3 - Clarified that local clinical documents may include aspects of medicines management.
- 7. Added ‘cognitive aid’ as a type of document.
- 9.1 - Reworded.
- Front page of Policy on Policies Template – addition of [IAST](#) confirmation of completion for Authors to complete.
- More explicit mention of those policies reserved for the Board

3.6 This policy deals with the **process** for policies. In line with a Special Measures milestone *1.9.3 “A stock take of all policies will be undertaken and Exec Team members asked to*

*prioritise the review of policies that they are responsible for*". The Governance Directorate is leading this and work is now underway to address the number of documents past their review date. This includes:

- A summary of overdue documents has been produced by the Governance Directorate and meetings arranged with all Executive Policy owners to progress a 12 month programme. Effectively this means agreeing with Executives a prioritisation of which policies will be reviewed and the method by which to review them
- Short term plans to review extant documents.
- Agree criteria to prioritise – (number of out of date documents and impact assessments by relevant Executives and Leads).

3.7 It is recommended that progress on this work is reported to the Audit Committee at the May 2024 meeting so that the process deployed and progress made can be scrutinised by the Audit Committee.

#### **Section 4. Declarations of Interest/Gifts & Hospitality Implementation Plan Update**

4.1 The Committee received a report in January 2024 with a detailed report on the level of Declarations of Interest/Gifts and Hospitality since the launch of the new Civica system in August 2023. The Audit Committee noted the improved position with a really positive uptake of Declarations received and that these have been shared with Counter Fraud team colleagues. The Audit Committee noted "partial assurance" from the report and asked that further development work be undertaken to allow better scrutiny of submission by Banding. A report will follow to show this in May Audit Committee.

4.2 Since the last Committee the Head of Corporate Affairs has met with Civica and Workforce colleagues in BCUHB during February to understand if further control measures are able to be added to the system to ensure that the essential criteria is able to be extracted from ESR.

#### **4.3 Progress Being Made**

4.3.1 The ESR data was referenced above was received week commencing 26 February 2024 and is in the process of being uploaded to Civica (once verified) and further work is required to ensure that Line Managers have approval of DOI's in the system in the next upload. Going forward a report will be run from ESR on the first of the month and uploaded to Civica to ensure data is accurate each month and a Standard Operating Procedure is in place with the Workforce Team to do this. In addition the Governance team are enabling the development of automatic emails from the system to remind colleagues about their duty to report their DOI's.

4.3.2 This work provides the opportunity to identify decision makers on the system, meaning that although all colleagues have a duty to report DOI's, those that have financial responsibility are targeted. While the Civica work targets all staff, Board Members declarations are sought in hard copy.

4.3.2 Given the above information the Audit Committee is asked to consider continuing partial assurance until the report is received in May.

#### **4.4 Next Steps**

- Ensure that Line Managers are live on the system to approve DOI's and that workforce data is uploaded.
- A report will be developed for the May 2024 Audit Committee.
- A forensic piece of work is ongoing in line with end of year accounts to ensure that Board Members DOI's are accurate and correlate to Companies House.

- New Board Members will be asked to make Declarations of Interest at their Induction and the Governance team will ensure there is correlation to Companies House data.

**Audit Committee****March 2024****Record of Breaches of Publication of Committee Papers since last reported to Audit Committee in January 2024, not in accordance with the normal Standing Orders**

<b>Meeting Date</b>	<b>Body</b>	<b>Standard</b>	<b>Issue/Reason for Breach</b>	<b>Details of papers</b>
25.1.24	Health Board public	Publication of papers 7 days before meeting	Follow on papers (F) Reload erroneous report (R)	F (W) CEO report F (W) Quality report CEO revision F (W/E) Joint Committee report R (E) Integrated Performance report F (W) MHL Committee report
25.1.24	Health Board Private	Publication of papers 7 days before meeting	Follow on presentation	Health Board Finance update (day before meeting)
25.1.24	Trustee Board	Publication of papers 7 days before meeting	Follow on papers erroneous report Reload	F (W/E) Annual Accounts and Annual report and reloaded post meeting

Philippa Peake-Jones  
Head of Corporate Affairs



# Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents

<b>Author &amp; Title</b>	Statutory Compliance, Governance & Policy Manager Acting Board Secretary & Associate Director of Governance
<b>Responsible dept / director:</b>	Director of Corporate Governance
<b>Approved by:</b>	Executive Team: 30/08/2023 Audit Committee: 15/09/2023 Executive Team: 28/02/2024 – for information Audit Committee:
<b>Date activated (live):</b>	September 2018
<b>Documents to be read alongside this document:</b>	OBS06 - BCUHB Integrated Assessment Screening Tool (IAST) WP7 - Procedure for Equality Impact Assessment
<b>Date of next review:</b>	xxx
<b>Date IAST Completed:</b>	Reviewed August 2023
<b>Date EQIA Completed - Integrated Equality Assessment (WP7)</b>	Reviewed August 2023

<b>First operational:</b>	June 2010 (CG01)				
<b>Previously reviewed:</b>	May 2011	Nov 2014	March 2016	July 2022	Aug 2023
<b>Changes made yes/no:</b>	Yes	Yes	Yes	Yes	Yes

*N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document being used. The Intranet should be referred to for the current version of the document.*

## Contents

1. INTRODUCTION.....	3
2. QUICK REFERENCE/HOW TO GUIDE/FLOWCHART.....	4
3. POLICY STATEMENT .....	5
4. PURPOSE.....	6
5. SCOPE.....	6
6. OBJECTIVES.....	7
7. DEFINITIONS.....	7
8. ROLES AND RESPONSIBILITIES.....	9
9. HEALTH BOARD WIDE POLICY ORGANISATION .....	12
10. POLICY DEVELOPMENT .....	12
11. IMPACT ASSESSMENTS .....	13
12. DOCUMENT FORMAT .....	15
13. CONSULTATION .....	15
14. APPROVAL PROCESS .....	17
15. REVIEW PROCESS.....	22
16. PUBLICATION, DISSEMINATION AND DISTRIBUTION .....	22
17. RESOURCES.....	24
18. TRAINING .....	24
19. IMPLEMENTATION .....	24
20. REVIEW .....	25
21. Appendix 1: Initial Approval Form .....	26
22. Appendix 2: Policy, Procedures and other Written Control Documents Template.....	29
23. Appendix 3: Supplementary Guidance for Completing the Policy Template.....	35
24. Appendix 4: Document Submission form for Uploading to the BCU Intranet Policies page .....	40

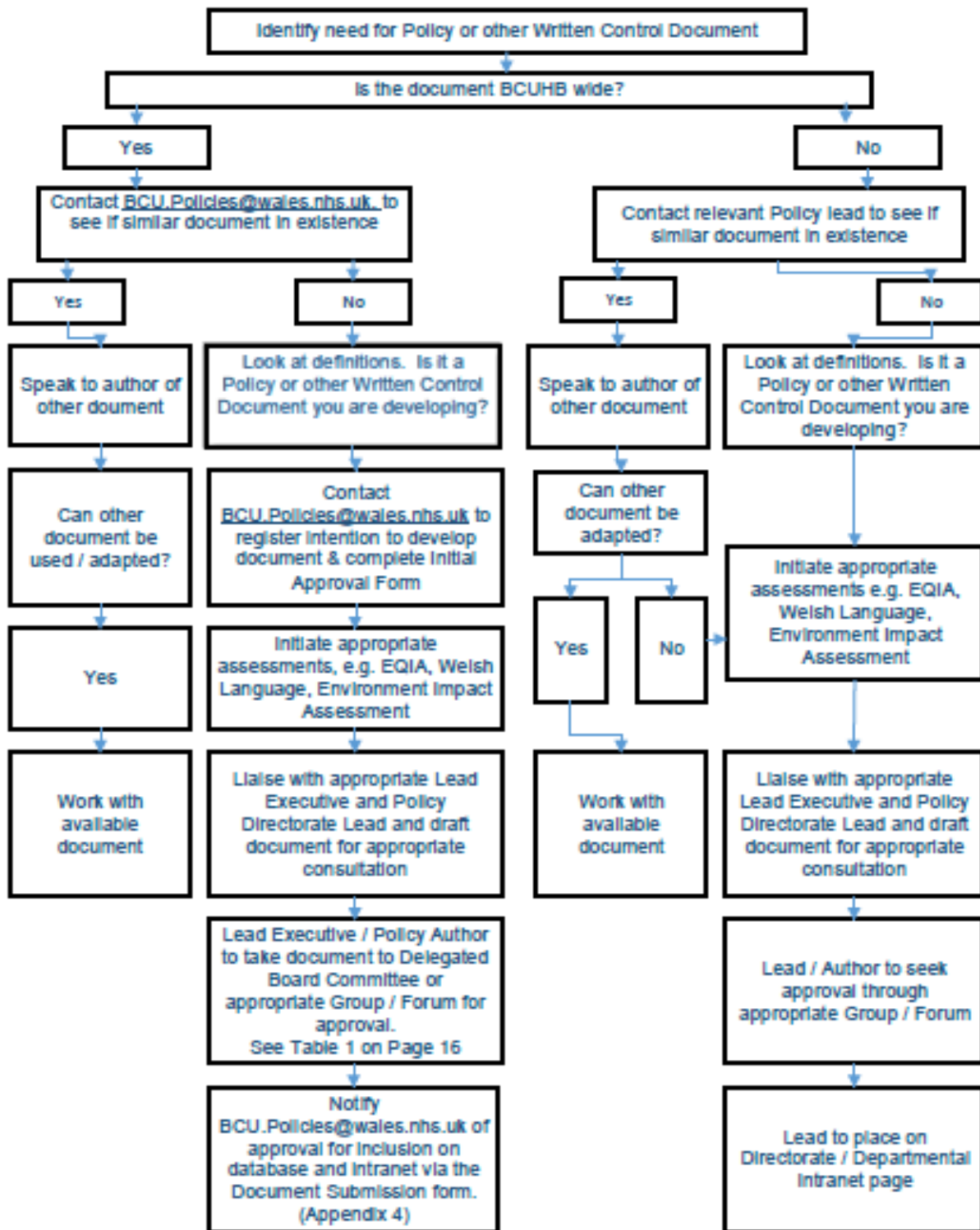
## 1. INTRODUCTION

1.1 BCUHB, subsequently referred to as the 'Health Board', has a statutory duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislative obligations, enabling employee/workers to fulfil their roles safely and competently.

1.2 Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees/workers and the Health Board. They help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance. This ensures the Health Board provides a robust and clear governance framework within which service delivery and operational activity can occur.

1.3 Through this policy, the Health Board ensures that there is a process whereby all Health Board wide policy documentation is consistent in format, compilation and dissemination. In addition, there is an effective process for managing and reviewing policies and any associated written control documents on a regular basis, to ensure that documentation remains legally compliant and actions are undertaken in a safe and efficient manner. This policy will ensure that the Health Board meets its legal responsibilities and provides a clear approach to policy and written control documentation, implementation and monitoring of compliance.

2. QUICK REFERENCE/HOW TO GUIDE/FLOWCHART



### 3. POLICY STATEMENT

The Health Board has a framework for the development, approval and dissemination of policies and other written control documents. This includes:

- Ensuring that employee/workers have access to the most recent copies of Health Board-wide documents – employee/workers should not print copies of policies/procedures and hold them locally – the intranet page will hold the definitive documentation;
- Having a control procedure for all Health Board policies and other written control documents to ensure that those in use are current and relevant and that duplication is avoided;
- Mandating that the equality impact assessment (EqIA) process is completed on all Health Board wide policies and other Written control Documents to ensure that decisions do not discriminate against people based on any protected characteristic, these are: race/ethnicity, sex, gender reassignment, disability, sexual orientation, religion or belief, age, marriage and civil partnership and pregnancy and maternity. Ensuring that policy makers are aware of the Health Board's legal duties around equality and human rights and that policy makers are aware of their responsibility to undertake EqIA necessary to inform evidenced based policy development and inclusive decision making.
- Having a corporate style and promoting the use of templates, to ensure a standard approach to the associated documentation;
- Ensuring systems exist and are used to monitor the use of, and compliance with, associated Health Board wide written control documents;
- Actively managing and maintaining a central database of Health Board wide policies, procedures and written control documents;
- Maintaining an archive of past documentation, for reference and to meet legal requirements.
- The Quality, Safety and Experience Committee and relevant corporate Patient Safety & Quality Group are key approval bodies in respect of all clinical policies and written control documents. Policy and working control documents involving medicines are considered clinical documents and will follow this approval route.

#### 4. PURPOSE

The purpose of this policy is to provide a framework and pathway for the continued development, approval and management of all Health Board wide policies and other written control documents across the Health Board and where required in partnership with external agencies.

#### 5. SCOPE

5.1 This Policy applies to all Betsi Cadwaladr University Health Board (BCUHB), employees and workers as defined by section 230 of the Employment Rights Act 1996. The scope includes, but is not limited to agency; board members; consultants, contractors; locums; office holders; students; vendors and volunteers, unless otherwise specified or a specific exemption applies in law or policy.

5.2 This policy sets out the route to be followed when developing or updating Health Board wide policies and other written control documents, and distributing them as appropriate within the Health Board. Policies and other written control documents that are not Health Board wide will be the responsibility of the relevant policy lead (see paragraph 8.7). The templates attached to this document may be used at a local level. However, the coordination of local procedures will be provided by the relevant policy lead.

5.3 A 'local' document refers to a departmental internal document. For example, a local document could be an individual Ward or Team 'how to' guide or cognitive aid that is deployed within an isolated area. Many such documents exist to support patient care at the front line, including documents that have aspects of medicines management. In many cases these documents reflect existing BCU policies, with the intention of bringing the policy to ward/service setting level. Being 'local' does not mean that the document lacks a governance structure, and such documents can expect to have been through the following process:

- Drafting by local subject matter experts with appropriate multidisciplinary input
- Review by local specialty core governance group
- Formal approval in local specialty Clinical Governance group meeting
- Approval by IHC Clinical Effectiveness Group (CEG) [clinical documents] or IHC Quality and Safety Group (QSG) [for non-clinical documents]

In some cases, it will be identified that a local document may be applicable to the entire health board. It is important for the sake of agility and to foster innovation, that such documents are initially approved for local use, whilst putting them forward for further pan-BCU approval.

Where IHC CEG/QSG have concerns about the scope of a document then advice can be sought from the relevant Executive / Office of the Board Secretary.

Local documents are subject to frequent revision based on clinical experience: revisions can be rapidly approved through the route described above.

Authors of 'local' documents are reminded that all Health Board records are subject to relevant legal obligations, including the Freedom of Information Act 2000, the Inquiries Act 2005, the Inquiry Rules 2006 etc., whether local or otherwise.

## 6. OBJECTIVES

6.1 The objectives of this policy are to enable Health Board wide consistency in the format, compilation and dissemination of such policies and other written control documents, ensuring that these are:

- Developed/reviewed in line with legal requirements;
- Considered and approved at the appropriate level, and within the Health Board by the appropriate Group, sub group, Committee or forum (with delegated powers and authority for approval);
- Implemented and cascaded to Health Board employee/workers with supportive information as appropriate;
- Supported by appropriate development and training throughout the Health Board;
- Available to the public in accordance with the requirements of the Freedom of Information Act 2000.

## 7. DEFINITIONS

7.1 Policies and supporting written control documents are essential in the delivery of high quality and safe health services and to ensure the Health Board operates within the law. They form an integral element of the governance and assurance framework by which the Health Board regulates its activities to achieve its goals, and are used as reference points to assist employees/workers in their day-to-day working.

7.2 Terminology across the range of documentation can often be confusing for both those that develop the documents and to those that use them. Clear definitions for these terms, highlighting the differences and similarities and the appropriate use of each is provided below:-

**Strategy** - A long-term plan designed to achieve particular goals or objectives that can be supported by policies and procedures.

**Policy** – A written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue.

Policies define the commitment of the Health Board and the obligations of individual employees/workers. A Policy describes the 'what' and the 'why'.

**Protocol** - a written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority. A protocol specifies the procedures to be followed in defined situations. Protocols are different from policies as they lack the 'mandatory' element by allowing for professional judgment and individual cases and competency to play a role.

**Procedure** - A standard method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures must be formulated using evidence-based knowledge and best practice.

**Guidelines** - give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.

**Standards** - provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence.

**Cognitive Aids** – exist to support frontline staff in the performance of their duties, and are usually a distillation/synthesis of existing policies, protocols, guidance and standards. These documents are generally developed locally (see section 5.3), are a short summary (e.g., a side of A4) of key points, and are subject to frequent revision based on clinical experience and feedback.

### 7.3 Documents Outside the Scope of this Policy

**Patient Group Directions (PGDs)** - provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). PGDs are managed in accordance with the Human Medicines Regulations 2012 and NICE Guidelines by the Pharmacy & Medicines Management Department (see MMPGD-01 Patient Group Directions, Procedure and Guidance for Authors and Users).

**Pathways** – Pathway development uses process management methodologies to review and re-design the patients journey to align with recognised best practice e.g., NICE, GIRFT or the National Optimal Pathway for cancer patients. Pathway redesign will incorporate scoping work and feedback from external reviews to ensure BCUHB develop an

organised, efficient and effective patient journey to enhance quality, standardise equity, reduce variability and optimise outcomes.

**Patient Information / Leaflets** – are managed in accordance with ISU02 Patient, Service User & Carer Procedure for the Production of Written Information. The procedure defines health information and provides the minimum standards required to ensure that information is produced in an easy to read, accessible, bilingual, Welsh and English format.

## 8. ROLES AND RESPONSIBILITIES

8.1 **Accountable Officer** - the Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Health Board has appropriate policies and other written control documents in place to ensure the Health Board works to best practice and complies with all relevant legislation.

8.2 **Board Secretary** - is responsible for the effective management of, and compliance with this policy. This includes ensuring that:

- A database of Health Board wide policies and procedures is maintained;
- Policies and procedures are approved as part of the Governance and Assurance Framework at the appropriate level in the Health Board;
- The documents are accessible to all relevant employees/workers;
- Documents are implemented and cascaded across the Health Board and the awareness is raised appropriately across the organisation;
- All Health Board wide policies and other written control documents are reviewed in a timely manner.

8.3 **Executive Directors** - are responsible for ensuring that all policies and other written control documents within their remit are maintained and updated by liaising with the appropriate policy author(s). They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are identified.

8.4 **Statutory Compliance, Governance & Policy Manager** – will act as the Health Board policy gatekeeper with the responsibility for providing guidance, training and support for the process. The Statutory Compliance, Governance & Policy Manager will:

- Manage the development and maintenance of the Health Board policy database;
- Manage the approval process in line with this policy;

- Cascade approved/amended policies and other written control documents in line with the Health Board communications system;
- Ensure Health Board wide policies and other written control documents are accessible via the Health Board's internet/intranet sites as appropriate;
- Maintain an archive of the previous versions of any revised or reviewed policy documents;
- Provide advice and assistance as required;

**8.5 Authors of Policies, Procedures and other Health Board wide Written Control documents** - are responsible for ensuring that the guidance provided in this policy is followed.

This will include:

- Liaising with Executive Leads to ensure that policies and other written control documents are implemented appropriately and, where necessary, compliance with those documents is formally audited;
- Ensuring that there is an appropriate review of policies and other written control documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, management structure or legislation;
- Ensuring that appropriate consultation has taken place with the relevant individuals and groups;
- Ensuring that training needs and resources required for implementation are clearly identified;
- Ensuring the necessary impact assessments have been carried out prior to the document entering the approval process (see Section 11);

8.6 Authors are responsible for their policy documents. If an author leaves the Health Board, the responsibility for their policy document is taken on by their role replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager or Director. This should be made clear in any handover arrangements. Notification should also be made to the Policy Leads.

**8.7 Policy Leads** - Policy Leads have been nominated by each Directorate/Division/Specialty/Corporate Function as appropriate. These Leads will:-

- In respect of BCU wide documentation act as the function gatekeeper for their respective areas of responsibility.
- Be responsible for acting as a gatekeeper and coordinator for all local written control documents (not BCU wide). They will be responsible for advising authors of their document's impending review, coordinating the production, version control (including archiving), local approval and dissemination of the documents. They will also be responsible for uploading the documents onto their area of the Intranet and updating their departmental database including maintaining an archive of historic local documentation.
- Ensure that any new employees/workers joining the Health Board are made aware of the policy control system at local induction, and how to access Health Board-wide and local policy documents specific to their area;
- Allocate an appropriate lead manager to take overall responsibility for the development and management of their respective policy documents in accordance with the Health Board policy process;
- Understand the policy process and their role in supporting best practice including the relevant impact assessment of all new or revised policies at the appropriate stage;
- Work with employees/workers without access to the intranet to ensure they have access to relevant documentation;
- Ensure that local arrangements are established to monitor the receipt and understanding of all relevant Health Board documents; thus, reducing the risk of misuse or misinterpretation.

**8.8 Line Managers** - at all levels managers are responsible for ensuring that employees/workers for whom they are responsible are aware of and adhere to this policy. This includes ensuring that:

- The Health Board policies and other written control documents are readily available and accessible to all employees/workers;
- Information is disseminated on a regular basis, to ensure employees/workers have read and understood the relevant documents and are aware of any new guidance or revisions;
- The identification of specific employee/worker training needs on the implementation of new or updated documents are addressed and linking with the relevant Executive Director where this might be a Health Board-wide need;
- Local systems exist to enable the review, audit and compliance testing of all relevant departmental policies, and other written control documents as required.

**8.9 All employees/workers** – are responsible for ensuring that:

- Their practice is in line with policies and other written control documents in use across the Health Board and specific to their area of work;
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their Line Manager and that the incident reporting system (i.e., DATIX) is used where appropriate;
- Information regarding any changes in practice, management structure or legislation that would require an urgent review of documents is immediately reported to their Line Manager;
- Compliance with this policy and where requested, can demonstrate such compliance. Failure to comply will be dealt with under the Health Board's Disciplinary Policies as appropriate.

**9. HEALTH BOARD WIDE POLICY ORGANISATION**

9.1 The diverse nature of health care means there will be a large number of policies and procedures in place. Although this policy primarily relates to the management of Health Board wide policies/documentation, it does provide some guidance around documents that can be held/approved locally, as well as suggested approval/decision pathway for such documents.

9.2 For ease of reference, all Health Board wide policy documentation will be listed and numbered under a series of headings. An index of policies and other written control documents will be maintained as part of the on-line database that is in place and maintained to manage the review process. The database will become the central register for all Health Board wide policies and other written control documents which apply across the Health Board.

**10. POLICY DEVELOPMENT**

10.1 Each Health Board-wide policy will be sponsored by a lead Executive Director. At Directorate/Divisional/Departmental/site level, policies and other written control documents will be sponsored by the appropriate Director or Divisional Director who will ensure that appropriate arrangements are in place for the creation, consultation and training and dissemination/storage/ accessibility of local procedures.

10.2 The development of new Health Board wide policies and other written control documents, or the amendment of existing documentation, will be overseen by the appropriate Executive/Divisional Director supported by the relevant governance lead. They will be responsible for ensuring that content and scope are fit for purpose before being presented for approval.

10.3 When the need for a new policy or written control document arises, the Office of the Board Secretary should be informed before preparation commences to ensure there is not a policy already in existence on the same or similar subject thus avoiding duplication of effort. Authors should complete Initial Approval Form (IAF) attached as Appendix 1.

10.4 Once the need and type of written control document is identified, the process for production and approval must follow that contained within this policy.

10.5 The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes (refer to Appendix 3). In accordance with the requirements of the Data Protection Act 2018 / GDPR, the names of individuals will not be contained within policies and other written control documents. Individuals with particular responsibilities will be identified by their job title only (In practice the name of the author is recorded in the Policy Management System as this proves useful when the procedure is going out of date and needs review).

10.6 All policy and written control document development should be undertaken in line with current legislation, national and professional guidance. Documentation should also be based on sound evidence and be appropriately referenced.

## 11. **IMPACT ASSESSMENTS**

11.1 As a public sector organisation, the BCUHB is bound by various legal obligations/duties that must be observed during the execution of its business. Impact Assessments are practical tools or mechanisms used to meet these duties in that they:

- measure the impact (both positive and negative) of a proposed action
- remove or mitigate negative impacts and maximise positive impacts
- facilitate and evidence 'due regard'

To have 'due regard' means that in carrying out all of its functions and day to day activities, a public authority subject to the duty, must consciously consider the needs of the general equality duty: eliminate discrimination; advance equality of opportunity and foster good relations.

Undertaking these assessments supports good decision-making based on evidence and consideration of how our decisions will affect our stakeholders (patients, employees/workers, carers, partner organisations). Failure to comply with these obligations could lead to legal challenge.

**11.2 The Integrated Assessment Screening Tool (IAST)** should be completed BEFORE commencing or reviewing and written control document. The IAST is a useful screening tool that summaries the various types of assessments / considerations that should be undertaken and signposts authors to the relevant documentation and/or Corporate Leads for further information. Certain impact assessments are **mandatory** for all documents:

- **Equality Impact Assessment (EqIA):** this provides a structured process set out in statute, which enables the organisation to consider the effects of its decisions, policies or services on different communities, individuals or groups. Please see WP7 - Procedure for Equality Impact Assessment for more information.
- **Welsh Language:** The Welsh Language standards are a set of statutory requirements and state clearly the Health Board's responsibilities to provide bilingual services to patients and the public. Under the standards, the Health Board must not treat the Welsh language less favourably than the English language. Further guidance is available via the Health Board's Guidance on applying the Welsh Language Standards Regulations 2018 under the Welsh Language (Wales) Measure 2011

Others relevant impact assessments will be dependent on the type of document being developed / reviewed:

- **Socio-Economic Impact Assessment (SEIA):** this assessment is required for strategic decisions and includes strategic decisions which are subject to review. In general, strategic decisions will be those which effect how Health Board fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions.
- **Data Protection:** Data protection impact assessments (DPIAs) are tools that will assist organisations in identifying the most effective way to comply with their data protection obligations and meet individuals' expectations of privacy. Carrying out a data protection impact screening assessment is a systematic way of doing this to establish if a full Data Protection Impact Assessment (DPIA) is required.
- **Rights of Children and Young People:** Children have needs and rights that are separate and different to adults. Authors should carefully consider whether the proposed written control document will have any impact on children and whether it will effectively protect and implement the rights expressed in the United Nations Convention on the Rights of the Child (UNCRC). The Social Services and Wellbeing (Wales) Act 2014 implements a duty that decision makers must have regard to the convention.
- **Older Person and/or People living with Dementia (including young onset dementia):** The Health Board has a duty to ensure older people have their

rights respected and are involved in decisions. All documents should be developed using a person-centered approach and ensure an evidence based approach in relation to the older adult and/or those with dementia (who may be under the age of 50 years). Due regard should be given to the United Nations Principles for Older Persons.

- **Carers:** The Social Services and Well-being (Wales) Act 2014 places a responsibility on the Health Board to identify unpaid carers, acknowledge their importance as an equal partner in care and provide them with information, advice and assistance.
- **Environment:** An Environmental Impact Assessment (EIA) is an assessment of the possible positive or negative impact that a proposed project may have on the environment, together consisting of the natural, social and economic aspects. The purpose of the assessment is to ensure that decision makers consider the ensuing environmental impacts when deciding whether to proceed with a course of action.

11.3 The outcomes of the IAST should then be used to inform the written control document development, promote a positive impact, mitigate any negative impact where possible and/or identify where further or specialist impact assessment may be necessary.

As part of any document development or decision, you should also consider how the document:

- Contributes to the social, environmental, economic and cultural well-being of Wales under the Well-being of Future Generations (Wales) Act 2015
- Impacts on Wales and the people who live and work here
- Supports the delivery of BCUHB objectives

## 12. DOCUMENT FORMAT

12.1 A document template together with supplementary guidance has been developed to provide clarification on what information should be included. It also contains the standard front cover that is to be applied to all Health Board wide policies and other written control documents, together with some specific points regarding formatting. See Appendices 2 and 3.

## 13. CONSULTATION

13.1 Policy and written control documents must not be written in isolation. All policies and other written control documents should be developed in consultation with their target audience involving managerial, clinical, employee/worker and patient involvement as appropriate. All new, or significantly revised, policies should be the subject of consultation within the

directorate / structure and with relevant professional groups and/or individuals. Policies or written control documents that include medicines must include a specialist lead pharmacist from that clinical area in the document development team.

13.2 For consultation, all Health Board-wide policy documents must be shared with:

- Relevant Executive Director / Senior Management.
- Employees/workers affected by the policy (including Trade Unions where relevant).
- Relevant clinical leads (medical, nursing, therapies, MH&LD, children's and older person etc.)
- Consideration should also be given to uploading to the Health Boards 'Draft Policies & Written Control Documents for Consultation' page with an accompanying notification in the Health Board's Corporate Bulletin to all employees/workers. This will be managed by the Office of the Board Secretary Policies Team.

DRAFT

## 14. APPROVAL PROCESS

14.1 The Health Board will be responsible for the approval of all Health Board wide policy documents. This responsibility can be delegated to an appropriate Committee, Executive, Group, Sub Group or Forum in the Health Board in accordance with the overarching Health Boards Governance arrangements i.e.:

- Approval retained by the Health Board
- Delegated to Health Board Committee
- Delegated to Health Board Executive
- Delegated to other Group or Partnership

14.2 All Wales Policy documents will also be approved for implementation and adoption in the organisation, via the route and should be accompanied by an Equality Impact Assessment completed by the sponsoring Executive Director.

A simplified approval route planner is detailed below in Table 1. Table 2 specifically relates to those policies that include medicines management:-

Table 1: Simplified Approval Route Planner

Document Type/Scope	Approval route in sequence order		
	1	2	3
Policies reserved as a matter for the board	Please refer to the Health Board Standing Orders, Scheme of Reservation & Delegation and the Office of the Board Secretary to confirm approval route.  The above documents reference the Health & Safety Policy, Standards of Business Conduct Policy, Counter Fraud Policy as reserved for the Board		
Clinical Policy BCU Wide	Relevant Specialist Governance Groups	Relevant Strategic Quality Group (i.e. patient safety, clinical effectiveness)	Executive Quality Group (to include approval of the Clinical Executives) and noted at QSE Committee.
Clinical Other written control document BCU wide	Relevant Local Specialist Governance Groups	Relevant Strategic Quality Group ( i.e. patient safety, clinical effectiveness) and note at Executive Quality Group	
Non-Clinical Policy BCU Wide	Relevant Local Governance Groups	HBLT/Exec Team and noted at relevant Committee	
Non-Clinical other written control document BCU wide	Relevant Local Governance Groups	Relevant BCUHB Corporate Group or Senior Management Team	
Clinical - Local Written Control document (i.e. below policy level) [see section 5.3]	Local Clinical Governance Group	IHC/Division Quality Group	
Non-Clinical – Local Written Control	Relevant Senior		

document (i.e. below policy level)	Management Team		
------------------------------------	-----------------	--	--

**Table 2: Documents that include Medicines Management**

Document Type/Scope	Approval route in sequence order			
	1	2	3	4
Any BCU Wide Policy which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant Strategic Quality Group (i.e. patient safety, clinical effectiveness)	Executive Quality Group (to include approval of the Clinical Executives) and noted at QSE Committee
Any BCU Wide written control document (below policy level) which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant Strategic Quality Group (i.e., patient safety, clinical effectiveness) and noted at Executive Quality Group.	
Patient Group Directives (PGDs) and BCU wide prescription charts	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group		

Shared Care Agreements Prescribing Guidelines, Standard Operating Procedures for switching treatments for General Practice	BRAG Sub group	Drug and Therapeutics Group		
----------------------------------------------------------------------------------------------------------------------------	----------------	-----------------------------	--	--

14.3 All Policies and Procedures involving medicines management are BCU wide, i.e. are applicable to patients pan BCU. Local clinical written control documents (as described in section 5.3) that involve medicines should be reviewed by local CEG/DTG in the first instance to determine whether escalation is necessary. This may include initially approving the document for local use while at the same time putting it forward for pan-BCU approval. For pan-BCU documents, in the event of a clinically urgent situation to meet a public health need, the document should be reviewed by both the Chair of Drug and Therapeutics Group and Chair of the relevant Corporate Quality & Safety Group. The Chairs will be given delegated authority to approve any specific documentation that will then be endorsed at the next meeting of both the Drug and Therapeutics Group and Corporate Quality & Safety Group.

14.4 Where Policies relate to Specialised and Tertiary Services, the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC). In relation to NHS Wales Shared Services the approval of policies relating to the business activities delivered by the Shared Services body on behalf of the Health Board will be delegated accordingly.

### **Clinical Policies and Procedures**

14.5 In the case of Health Board wide policies for clinical practice, the Relevant Corporate Quality & Safety Group will receive and approve all clinical policies with Health Board-wide implications, prior to their ratification by the relevant Exec (or Committee/Board for matters that are reserved).

14.6 The relevant Corporate Quality & Safety Group will also discuss and identify the need for Health Board-wide policies for clinical practice arising from recommendations from audit, NICE, external reports etc. and issues arising from changes in evidence-based practice and take action as appropriate. All new policies must be evidence based and aligned to best practice and where relevant have input from service users and carers.

14.7 All Clinical Policies should be developed using a person-centered approach. Existing Policies should be reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures should be developed with input from experts.

Within the policy development process, it is important to consider both physical health and mental health conditions that may require a particular attention or focus, this may be related to short and long term needs and conditions, i.e.: acute medical or surgical conditions, injuries, mental health, neurological conditions, dementia and learning disability.

All people, at some stage in their life maybe in a vulnerable circumstance or require additional care and support when accessing healthcare services, therefore, in the development and/or renewal of all BCUHB polices this must be realised by giving consideration to the broad range of issues, which may impact upon an individual (and their families or carers) in how they understand, consent, and receive healthcare.

The vulnerability should be considered in any of the associated health interventions required and the related polices applied. The policy developer should address pertinent aspects identified within the policy that may relate to a person with specialist needs.

It is important for all policy developers to ensure they have considered the above elements in the development and renewal processes of all polices. The policy owners and developers should consider engaging the appropriate specialist medical/nursing/AHP practitioners when further expertise is required in a particular aspect of the policy. All policy developments must reflect the consideration in given in context of the individual circumstance, biopsychosocial needs and the legal guidance framework under the Mental Capacity Act.

14.8 Policies and written control documents that include medicines are to be approved by the Health Board's Medicines Policy, Procedures and PGD Sub Group and should be submitted to the chair of that group for review and approval. Decisions taken at the above Sub Group will then be ratified by the Health Board's Drug and Therapeutics Group at its subsequent meeting. Polices and written control documents that include medicines must not be uploaded onto the Health Board's intranet until formal approval and endorsement has been given by the Health Board's Drug and Therapeutics Group.

14.9 The approval of policy documents will be retained by the Board or delegated to Health Board Committees in line with their individual remits and responsibilities. This will be reflected in the Health Board's overarching governance arrangements.

14.10 The Office of the Board Secretary will ensure that all Health Board wide approved policies and other written control documents are recorded in the

Health Board Policy Register and published on the intranet site and that there is clear revision control applied to policies.

14.11 A submission checklist must be completed for each document to be uploaded to the intranet and submitted to the Office of the Board Secretary. The checklist is attached as Appendix 3.

14.12 All policies, procedures, protocols and guidelines must be produced by using corporate templates. The Board or relevant Committee will not ratify documents that do not comply with this policy.

## 15. REVIEW PROCESS

15.1 Good governance requires that certain policies must be reviewed annually. These are:

- Risk Management Strategy and Policy
- Major Incident Plan

15.2 All other policy documents must be reviewed no later than three years after initial approval and regularly reviewed on the same basis thereafter. Documents will be reviewed more frequently if changes in legislation or the service requires it. Until a document is reviewed, it will remain the extant policy document of the Health Board until replaced. It is the responsibility of the policy or written control document author to ensure that documents are reviewed in line with their review dates.

15.3 Where a review forms part of a document periodic review as per the review cycle (i.e., minimum of three years), the full approval process as detailed in Table 1 must be observed, even if there are no changes. This is to ensure the Health Board maintains a periodic overview of its library.

15.4 Where a periodic review necessitates considerable change to the previous document, the process will be treated as though it is a new document, for dissemination and training. Minor amendments can be notified by distributing copies of the document to appropriate recipients, with a cover sheet annotating where and what the changes are and their implications. This sheet should be kept with the original but copies cascaded to appropriate members of employees/workers. Policy Leads/Authors must ensure that a copy of the revised document is sent into the Office of the Board Secretary with a note of the revisions.

15.5 In all cases, the review should include a review of the original Equality Impact Assessment (where one exists) or the drafting of a new Assessment where this has not previously been undertaken (or cannot be located).

## 16. PUBLICATION, DISSEMINATION AND DISTRIBUTION

16.1 All policies and other written control documents that have been ratified appropriately must be forwarded to the Office of the Board Secretary within ten working days of approval. They will then ensure that the document is:

- Added/updated on the BCUHB Policy database;
- Cascaded in line with the Health Board communications system and included in the weekly Corporate Bulletin.
- Uploaded onto the BCUHB Policies, Procedures and other Written Control Documents Intranet page.

16.2 The intranet site will be the primary location for all Health Board wide policies and other written control documents to ensure that employees/workers can access the most up to date versions. Employees/workers should not print copies and hold them locally. Where a hard copy is required e.g., for team briefing/reference purposes etc. these should be downloaded from the intranet site by the appropriate Line Manager who will be responsible for ensuring their destruction following the briefing.

16.3 All documents will be subject to the BCU version control standard operating procedure and archived in line with legal requirements. Once revised policies and other written control documents are approved, the Office of the Board Secretary will e-mail the author/policy lead to inform them in order that they can ensure appropriate dissemination to their teams.

16.4 Once issued, Policy Leads together with individual line managers will be responsible for ensuring that all employees/workers are aware of the revisions and that any out-of-date versions are taken out of local circulation. Each Directorate or Division will put in place a robust controlled records management system.

16.5 This policy and any associated written control documents will be distributed in accordance with this policy and made available on the Health Board intranet site.

16.6 Policies and written control documents that are non BCU wide should be forwarded to the relevant Directorate Policy Lead for appropriate publication, dissemination and distribution.

## 17. RESOURCES

17.1 A policy management database has been established and will be further developed in support of this policy. Resources will be utilised as within current structures.

17.2 Resources in terms of time will be required to educate employees/workers on both the requirements of this policy and the development of documents across the Health Board. This will need to be identified within each Directorate.

## 18. TRAINING

18.1 All Executive Directors will work with the Executive Director of Workforce and Organisational Development to ensure that there is an ongoing training programme for all employees/workers that incorporates the implementation of policies and other written control documents. Key subject areas will be included at local induction and as part of employees/workers development processes.

18.2 Line Managers must ensure that new starters are aware of this policy, induction arrangements and of their individual departmental processes.

18.3 It is the responsibility of individual Line Managers to inform the Executive Director of Workforce and Organisational Development of the requirement where specific employees/workers training needs are identified, particularly in relation to the implementation of new or updated documents.

18.4 Executive Directors will ensure that responsibilities for policy development are clearly outlined in relevant Job Descriptions, in accordance with roles.

## 19. IMPLEMENTATION

19.1 It is the responsibility of the author to identify how any policy or written control document will be implemented. This will include liaising with Workforce and Organisational Development in order to ensure that employee/worker training requirements have been highlighted in time for the policy document to go live. This will avoid any confusion in changes of practice or resources required of the new or updated policy document.

19.2 Executive Directors and Policy Leads have key implementation roles in this policy and should ensure that information is cascaded appropriately to the employees/workers within their divisions and localities.

20. **REVIEW**

20.1 This policy will be reviewed every three years, or sooner should the author or legal requirements deem it relevant or required. This policy has been subject to Equality Impact Assessment screening.

DRAFT

Reference number (to be allocated by Office of Board Secretary)

## 21. Appendix 1: Initial Approval Form



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

### BCUHB-wide Policy Initial Approval Form

This form should be completed and approval obtained before you start producing your policy document. The Equality Impact Assessment should also have been started and any Welsh Language requirements considered. **To be completed by document author(s)/group.**

For any help or guidance please contact: [BCU.Policies@wales.nhs.uk](mailto:BCU.Policies@wales.nhs.uk)

<b>Document title:</b> <i>Insert Title</i>	
<b>Please indicate what type of document e.g., Policy, Procedure, Guideline etc:</b>	
<b>Is this a new document or replacement?</b>	
<b>Brief Summary:</b>	
<b>Reason for the review:</b>	<b>Tick to indicate</b>
Aligning services/changing service (i.e., re-organisation):	
Amendments to documentation needed:	
New/amended legislation:	
Review date approaching:	
Supporting National guidelines, policies, legislation, standards:	
Other:	
<b>Document(s) this will replace:</b>	
Previous organisation policy/procedures – Name/number : Please also provide a link to existing location	
<b>Responsible Directorate:</b>	
Area that is responsible for creating, updating, monitoring the document/elements the document specifies:	
<b>Responsible Executive Director/Director:</b>	
NB. Your Executive Director is ultimately responsible for this document, so it is important that they are aware of the document's production.	

<p><b>Has the responsible Executive Director/Director approved the instigation of this document?</b>  Yes: <input type="checkbox"/> No: <input type="checkbox"/>  If no, please state why</p> <p><b>Will they be informed?</b>  Yes: <input type="checkbox"/> No: <input type="checkbox"/>  If no, please state why:</p>
<p><b>Responsible Author: (i.e., nominated by the Executive Director/Director)</b></p>
<p><b>Working Group: (please detail who is involved – include job titles)</b></p>
<p><b>Engagement to take place with relevant stakeholders (please ensure you detail exactly who you are engaging with):</b></p> <p><b>Method of engagement (for the draft document)</b></p> <p>Meeting: <input type="checkbox"/>  Email: <input type="checkbox"/></p> <p><b>Union representative must be consulted for all Workforce/HR related Policies</b></p> <p>Yes: <input type="checkbox"/> No: <input type="checkbox"/>  If no, please state why</p>
<p><b>Local Counter Fraud</b>  Certain policy documents require input from your Local Counter Fraud Specialists. If your document content involves patient or employees/workers claim forms or other financial records please ensure your draft document is sent to <a href="mailto:Karl.Woodward@wales.nhs.uk">Karl.Woodward@wales.nhs.uk</a> as part of the consultation process. Please tick here if this is the case:</p> <p>Yes: <input type="checkbox"/> No: <input type="checkbox"/>  If no, please state why</p>
<p><b>Welsh Language</b>  If your document will impact on patient /user experience please ensure you send your draft document to: <a href="mailto:Eleri.Hughes-Jones@wales.nhs.uk">Eleri.Hughes-Jones@wales.nhs.uk</a> (Welsh Language Services Manager). Please tick here if this is the case:</p> <p>Yes: <input type="checkbox"/> No: <input type="checkbox"/>  If no, please state why</p>
<p><b>Resource implications associated with implementing this Policy:</b></p>

<b>Financial:</b>  <b>Training / employees/workers time:</b>	
<b>Have these been discussed/resolved within your Division/Directorate/Corporate Department?</b> Yes: <input type="checkbox"/> No: <input type="checkbox"/>  <b>Details:</b>	
<b><u>Timescales envisaged</u> – please give details. An action plan can be submitted for further clarification:</b> Equality Impact Assessment screening and produce final draft version: <a href="#">The Equality Impact Assessment</a>  Approval and endorsement:  Implementation:  Training:	
<b><u>Monitoring arrangements.</u> Please detail here how the document / process within the document will be monitored: Through designated Lead</b>	
<b>Is this an All Wales document? tick if applicable: <input type="checkbox"/></b>	
<b>What are the legislative or statutory elements of this document?</b>  N/A	
<b><u>Approval:</u> where do you envisage this Policy will be approved?</b>	Patient Safety & Quality Group <input type="checkbox"/>  Executive Team <input type="checkbox"/>  Committee <input type="checkbox"/>
<b>Please state which Board Committee (if applicable): Professional Advisory Group</b>	
<b>Any additional comments regarding the Policy:</b>	

Please return this form to: [BCU.Policies@wales.nhs.uk](mailto:BCU.Policies@wales.nhs.uk)

**22. Appendix 2:  
Policy, Procedures and other Written Control Documents Template**



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**Version &  
Reference  
Number**

**Title Here**

<b>Author &amp; Title</b>					
<b>Responsible Dept / director:</b>					
<b>Approved by:</b>					
<b>Date approved:</b>					
<b>Date activated (live):</b>					
<b>Documents to be read alongside this document:</b>					
<b>Date of next review:</b>					
<b>Date IAST Completed:</b>					
<b>Date EQIA Completed - Integrated Equality Assessment (WP7)</b>					
<b>First operational:</b>					
<b>Previously reviewed:</b>					
<b>Changes made yes/no:</b>					

*N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.*

## CONTENTS

1. INTRODUCTION/OVERVIEW .....	31
2. POLICY STATEMENT .....	31
3. AIMS/PURPOSE .....	31
4. OBJECTIVES .....	31
5. SCOPE .....	31
6. ROLES AND RESPONSIBILITIES .....	31
7. MAIN BODY .....	31
8. EQUALITY INCLUDING WELSH LANGUAGE .....	32
9. WELL-BEING OF FUTURE GENERATIONS .....	32
10. ENVIRONMENTAL IMPACT .....	32
11. RESOURCES .....	32
12. TRAINING .....	32
13. IMPLEMENTATION .....	33
14. FURTHER INFORMATION - CLINICAL DOCUMENTS .....	33
15. AUDIT .....	33
16. REVIEW .....	33
17. REFERENCES .....	33
18. APPENDICES .....	34

DRAFT

## **1. INTRODUCTION/OVERVIEW**

What is it about? Why is it needed? This may require information relating to audit, risk management, quality and safety.

## **2. POLICY STATEMENT**

What is the commitment of the Health Board? What is the statement of intent?

## **3. AIMS/PURPOSE**

What is the purpose of the document?

## **4. OBJECTIVES**

What will the document achieve?

## **5. SCOPE**

Who does the document relate to:

- All Employees/workers?
- Directorate/Division/Area/Site/Clinical/Department specific?

## **6. ROLES AND RESPONSIBILITIES**

Who is responsible for implementation?

- Which groups of staff are able to carry out the procedures required?
- What action points does the document raise?
- Who is responsible for ensuring action points are undertaken?
- Who is accountable if the responsibilities are not followed?

## **7. MAIN BODY**

Show how the document statement will be achieved. Reference evidence appropriately.

## 8. EQUALITY INCLUDING WELSH LANGUAGE

- Has an equality impact assessment been carried out?
- Has any adverse impact been identified? If so, is it justified and lawful?
- Describe any measures taken to mitigate or remove the adverse impact.
- Have the effects of the policy decision (whether positive or adverse) been considered in terms of the opportunities for people to use the Welsh Language and treating the Welsh Language no less favorably than the English Language.
- Explain how the document eliminates unlawful discrimination, harassment and victimisation, promotes equality of opportunity and/or good relations between different groups.

## 9. WELL-BEING OF FUTURE GENERATIONS

Indicate how the provisions of the WFG Act are being address and demonstrate that all key goals have been considered in the development of the document.

## 10. ENVIRONMENTAL IMPACT

- Does an Environmental Impact Assessment need to be carried out? For further information contact :-
  - BCUHB **East** – Environment Officer 01978 727500
  - BCUHB **Central** – Environment Officer 01745 445979
  - BCUHB **West** – Environment Officer 01248 385324

## 11. RESOURCES

Are there any resource issues in order for the document to be implemented?

Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.

## 12. TRAINING

Are there any training issues and if so, who is responsible for the training programme?

- Who will keep a record of those members of staff who have been trained?
- Will there be update training? How often?
- If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy?

- Where appropriate, specify the grade and required education and training of staff implementing the document.

### **13. IMPLEMENTATION**

How will the document be implemented?

- Action Plan?
- Time Scales?
- What level of training should they have?

### **14. FURTHER INFORMATION - CLINICAL DOCUMENTS**

The evidence base provided for the document. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.

All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should be written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

### **15. AUDIT**

This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. A suitable audit mechanism should therefore be described within the policy document.

### **16. REVIEW**

Generally, 3 years unless legislation requires differently – check with the Office of the Board Secretary.

### **17. REFERENCES**

All reference material should be listed in full at the end of every document in Harvard style

## **18. APPENDICES**

To include any procedures, protocols or guidance applicable to the policy.

The above headings are key to good implementation and essential to clinical policy development, they are not exhaustive and other headings will apply to individual documents.

### Appendix 3:

#### SUPPLEMENTARY GUIDANCE FOR COMPLETING THE POLICY TEMPLATE

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Left aligned
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Health Board logo.
Headers and footers	Aerial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header or footer on every page
Page numbering	To be included in the footer (e.g., page x of x)
Bullets	<ul style="list-style-type: none"><li>• Use standard bullets only, as they do not always format across different systems.</li></ul>
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.

Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore, all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Office of the Board Secretary. Documents to state 'Draft' whilst in development.

**All Policies must include the following headings as a minimum.**

Introduction/Overview	What is it about? Why is it needed? This may require information relating to audit, risk management, quality and safety.
Statement	What is the commitment of the Health Board? What is the statement of intent?
Aims/Purpose	What is the purpose of the document?
Objectives	What will the document achieve?
Scope/Area of Application	Who does the document relate to: - All Employees/Workers? - Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	- Who is responsible for implementation? - Which groups of staff are able to carry out the procedures required? - What action points does the document raise? - Who is responsible for ensuring action points are undertaken? - Who is accountable if the responsibilities are not followed?
Main Body	Show how the document statement will be achieved. Reference evidence appropriately.

<p>Equality, Well-being and the Environment (including Welsh Language Requirements)</p>	<p>- Has an equality impact assessment been carried out? If 'yes', append it. If 'no' explain why not.</p> <p>- Has any adverse impact been identified? If so, is it justified and lawful? Describe any measures taken to mitigate or remove the adverse impact.</p> <p>Explain how the document eliminates unlawful discrimination, harassment and victimization, promotes equality of opportunity and/or good relations between different groups.</p> <p>Welsh Language Standards should be maintained – when a policy is formulated or reviewed/revised the effects of the policy decision (whether positive or adverse) need to be considered in terms of the opportunities for people to use the Welsh Language and treating the Welsh Language no less favorably than the English Language. Contact Alaw.Griffiths@wales.nhs.uk from the Welsh Language Team for assistance.</p> <p>Indicate how the provisions of the WFG Act are being address and demonstrate that all key goals have been considered in the development of the document.</p> <p>Does an Environmental Impact Assessment? need to be carried out? For further information contact:-</p> <ul style="list-style-type: none"> <li>• <b>BCUHB East</b> – Environment Officer 01978 727500</li> <li>• <b>BCUHB Central</b> – Environment Officer 01745 445979</li> <li>• <b>BCUHB West</b> – Environment Officer 01248 385324</li> </ul>
<p>Resources</p>	<p>Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.</p>

<p>Training</p>	<ul style="list-style-type: none"> <li>• Are there any training issues and if so who is responsible for the</li> <li>• training programme?</li> <li>• Who will keep a record of those members of staff who have been trained?</li> <li>• Will there be update training? How often?</li> <li>• If the document compliance is not carried out for any length of time at</li> <li>• what stage will the person cease to be authorised to carry out that</li> <li>• policy?</li> <li>• Where appropriate, specify the grade and required education and training of staff implementing the document.</li> </ul>
<p>Implementation</p>	<p>How will the document be implemented?</p> <ul style="list-style-type: none"> <li>- Action Plan?</li> <li>- Time scales?</li> <li>- What level of training should they have?</li> </ul>
<p>Further Information Clinical Documents:</p>	<p>The evidence base provided for the document. Name any recognised relevant professional body, for example the source of your evidence base.</p> <p>Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.</p> <p>If medicines are referred to within the document IT must have had prior approval by the BCUHB Medicines Policy, Procedures and Patient Group Direction Sub-Group and Drug and Therapeutics Group.</p>
<p>Audit</p>	<p>This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.</p>

Review	Generally, 3 years unless legislation requires differently – check with BCU.Policies@wales.nhs.uk
--------	---------------------------------------------------------------------------------------------------

**Approvals – quick reference guide**

Refer to **Item 14** in OBS01 - *A simplified approval route planner is detailed in Table 1. Table 2 specifically relates to those policies that include medicines management.*

**In addition to the above** - Further details are below regarding Clinical approvals at relevant BCUHB Corporate Groups:

<b>Group</b>	<b>Frequency</b>	<b>Chair</b>
Strategic Health Board Patient Safety Group	Quarterly	Deputy Executive Director of Nursing
Strategic Patient and Carer Experience Group	Quarterly	Deputy Executive Director of Nursing
Strategic Clinical Effectiveness Group	Monthly	Deputy Executive Medical Director
Strategic Infection Prevention and Control Group	Quarterly	Executive Director of Nursing and Midwifery
Strategic Safeguarding Governance and Performance Group	Quarterly	Director of Safeguarding and Public Protection

**If you require further guidance in relation to non-clinical Groups please contact:**  
[BCU.Policies@wales.nhs.uk](mailto:BCU.Policies@wales.nhs.uk)

**24. Appendix 4: Document Submission Form for Uploading to the BCU Intranet Policies page**

<b>Document Title:</b>			
<b>Document Type / Target Audience: (PLEASE TICK/SELECT)</b>			
BCUHB Wide		Guideline	
Directorate/Department/Area Specific		Standard	
Strategy		Protocol	
Procedure		Other	
Policy			
<b>Document Lead:</b>			
Name:		Email Address:	
Job Title:		Contact Number:	
<b>Is this document new or does it replace an existing document(s): (PLEASE TICK/SELECT)</b>			
New			
Replacement			
If replacement please provide the title and code below to the document which is to be removed:-			
<b>Please select the section on BetsiNet policy and procedure page that you require this to be placed on (please tick):</b>			
All Wales DNACPR	Ophthalmology		
Anaesthetics, Critical Care & Pain Management	Organ Donation		
Cancer, Palliative & Clinical Haematology	Palliative and End of Life Care		
Charities and Volunteers	Pathology		
Children and Young People	Patient/Health Records		
Emergency Planning and Business Continuity	Pharmacy and Medicines Management		
Estates and Facilities	Primary Care and Specialist Medicine		
Finance	Quality, Patient Safety and Experience		
Health and Safety	Radiation Protection		
Immunisation	Radiology		
Infection Prevention and Control	Research and Development		
Informatics	Resuscitation		
Information Governance	Risk Management		
Massive Haemorrhage	Safeguarding		
Medical Devices	Tissue Viability		
Mental Health & Learning Disabilities	Therapies and Health Sciences		
Nursing & Clinical	Welsh Language		
Office of the Board Secretary	Women's Directorate		
Office of the Medical Director	Workforce		
Operational Management	Other ( <i>Please specify new category below</i> )		
<b>New Category :</b>			

<p><b>Teitl adroddiad:</b></p> <p><i>Report title:</i></p>	<p><b>2023/24 Annual Accounts (Final dates) &amp; Initial Key Areas of Judgment</b></p>
<p><b>Adrodd i:</b></p> <p><i>Report to:</i></p>	<p>Audit Committee</p>
<p><b>Dyddiad y Cyfarfod:</b></p> <p><i>Date of Meeting:</i></p>	<p>Friday, 15 March 2024</p>
<p><b>Crynodeb Gweithredol:</b></p> <p><i>Executive Summary:</i></p>	<p>The purpose of this report is to provide an update on the preparation of the 2023/24 Annual Accounts process by confirming the final confirmed dates for submission; and to provide an initial indication of the key areas of judgement.</p> <p><b><u>2023/24 Submission Timetable (Final)</u></b></p> <p>The timetable has now been finalised and confirmation received that the Draft Accounts are due for submission to Welsh Government by the 3<sup>rd</sup> May 2024. This will be followed by the various supporting Annual Reports (Annual Governance Statement incorporating the Remuneration, Duty of Quality and Candour Reports; and Performance Report) by the 10<sup>th</sup> May 2024. Audit Wales have indicated that the field work will be completed by the end of June 2024 and the Final Audited Accounts submission date (Auditor General to submit to Welsh Government) is the 15<sup>th</sup> July 2024.</p> <p>An Audit committee Development Session on the Draft Accounts is planned for the 21<sup>st</sup> May 2024. The Audit Wales ISA260 and Opinion is expected by 3<sup>rd</sup> July 2024 and an extraordinary Audit Committee and Board Meeting to endorse the Final Accounts is planned for the 10<sup>th</sup> July 2024.</p> <p>Once signed, the Accounts will then be consolidated and sent to the Auditor General for signature on the 12<sup>th</sup> July 2024, enabling the laying of the Accounts on the 15<sup>th</sup> July 2024. The date and location for the Annual General Meeting will be confirmed in due course.</p> <p>I would also draw members attention to the positive and continued engagement that has taken place throughout the 2023/24 financial year, with a number of workshops now completed to include the Financial Accounts teams and members of Audit Wales, with the express aims of improving the production and audit of the Annual Financial Statements. I would like to place on record my thanks for</p>

	<p>Audit Wales active participation in these sessions and engagement with BCUHB.</p> <p><b><u>Key areas involving judgement</u></b></p> <p>There will be a number of key areas within the draft Annual Accounts where the values recorded in the financial statements involved judgement and estimation. Estimates will be reflected in the draft 2023/24 Annual Accounts based on best information at that point in time. They are effectively under review up to the point of finalising the Annual Accounts. Should circumstances at finalisation warrant materially different estimates at that time, it will be necessary for the Health Board to amend its draft Annual Accounts to reflect a true and fair view.</p> <p>The key judgements and changes in estimations material in nature will be debated with Audit Wales, with key known areas relating to the following (further details are contained within Appendix 1):</p> <ul style="list-style-type: none"> <li>• Provisions for legal or constructive obligations for clinical negligence, personal injury and defence costs</li> <li>• Provisions for claims for Continuing Healthcare (subject to further review)</li> <li>• Contracted Primary Healthcare</li> <li>• Annual leave not taken by staff at year-end</li> <li>• Medical Study Leave Cover</li> <li>• Invoices on Hold “No Purchase Order No Payment”</li> </ul>
<p><b>Argymhellion:</b></p> <p><b><i>Recommendations:</i></b></p>	<p>The Audit Committee is asked to note the engagement that has occurred with Audit Wales post submission of the 2022/23 Annual Accounts, the work undertaken throughout the year and further the timeframe, key dates for review, Audit and submission of the 2023/24 Annual Accounts.</p> <p>The Audit Committee is asked to note the initial key areas where the values recorded in the 2023/24 Annual Accounts will be based on a judgement (estimation). Further details will be shared at the planned Audit Committee Development Session on the 21<sup>st</sup> May 2024.</p>
<p><b>Arweinydd Gweithredol:</b> <b><i>Executive Lead:</i></b></p>	<p>Russell Caldicott, Interim Executive Director of Finance</p>
<p><b>Awdur yr Adroddiad:</b> <b><i>Report Author:</i></b></p>	<p>Andrea J Hughes, Interim Finance Director – Operational Finance</p>

<b>Pwrpas yr adroddiad: Purpose of report:</b>	<b>I'w Nodi For Noting</b> <input checked="" type="checkbox"/>	<b>I Benderfynu arno For Decision</b> <input type="checkbox"/>	<b>Am sicrwydd For Assurance</b> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd: Assurance level:</b>	<b>Arwyddocaol Significant</b> <input type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol Acceptable</b> <input checked="" type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol Partial</b> <input type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd No Assurance</b> <input type="checkbox"/>  Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b>  <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>		This paper aligns to the strategic goal of attaining financial balance.		
<b>Link to Strategic Objective(s):</b>				
<b>Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:</b>		Statutory requirements for the Health Board to produce a set of Audited Annual Accounts for the Auditor General for Wales for the Welsh Government and for laying at the Senedd.		
<b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqlA been identified as necessary and undertaken?</b>		Not necessary		
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>		Not necessary		

<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	<p>BAF: 2.3 – Plan to reduce BCUHB's Financial deficit, secure WG funding and retain WG's strategic support</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <i>Financial implications as a result of implementing the recommendations</i></p>	<p>There will be a number of key areas within the Annual Accounts where the values recorded in the financial statements involved judgement and estimation.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Whilst there has been proactive liaison and communications with staff and their representatives with regards to the Annual Leave Policy, this may be also required in the near future in regards to the continued entitlement of Medical Study Leave accumulated during the pandemic.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <i>Feedback, response, and follow up summary following consultation</i></p>	<p>Not applicable</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>See above</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b> <i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable</p>
<p><b>Camau Nesaf:</b> <i>Next Steps:</i> The report is for assurance – further details on the content of the Draft Accounts (including key areas of judgment) will form part of the Audit Committee Development Session on the 21<sup>st</sup> May 2024.</p>	
<p><b>Rhestr o Atodiadau:</b> <i>Appendices:</i></p> <p>Appendix 1: Initial key areas of judgement</p>	
<p><b>Appendix 1:</b></p> <p><b>Provisions</b></p>	

Provision details (in the previous financial year these totalled c £111 million) will be shown in the notes to the Accounts. They relate primarily to claims for clinical negligence, personal injury and defence costs and are covered by an All-Wales Risk Pool arrangement. The value of these provisions will be informed by the year end Welsh Risk Pool Report provided by the NHS Wales Shared Services Partnership.

Debtors related to Risk Pool recoveries will also be shown in notes to the Accounts. In the previous year these totalled c£120 million. In addition, there will be gross contingent liabilities (including remote) disclosed in the Accounts for commitments that have yet to reach the point of recognition (in the previous year these amounted to c £214 million with £36 million being remote).

Whilst the Health Board is largely protected from the full cost of claims by the All-Wales Risk Pool, the overall position of the arrangement and participants' respective shares are dependent upon individual cases being accounted for correctly by each Health Board and successfully consolidated as a representative All-Wales position. Claims that qualify for treatment in the Welsh Risk Pool follow a recognised All-Wales process. The Health Board's Quality team deal with individual claims and the financial aspects are dealt with by the Finance Team in line with agreed process, which has been followed throughout the 2023/24 financial year.

The Risk Pool now applies penalties in cases where the speed of capture and progress of individual cases by Health Boards has been deemed inadequate, specifically where approval of learning has been deferred for over 12 months. The Quality Team assess and mitigate potential exposure to penalties and look to identify other opportunities to improve the processing of claims.

Also, to be included within the year-end provisions, will be the Continuing Healthcare Claims, which remain subject to further review. These will be incorporated into the draft accounts based on best information case-by-case at the time. In the previous financial year these totalled c £5.7m.

### **Contracted Primary Healthcare**

The Health Board makes significant year-end accruals for its services with Primary Care Contractors (GP Practices – General Medical Services (GMS), Primary Care Dentists – General Dental Services (GDS), Community Pharmacies, and High Street Optometrists – General Ophthalmic Services (GOS)).

These accruals arise because payments are often in arrears based on agreed timeframes where Contractors are allowed to claim reimbursement. The accruals represent prudent estimates of the Primary Care costs incurred that relate to the accounting period but claimed after the period end. The most significant estimates relate to GP Prescriptions (in the previous financial year these totalled c£25 million), as the claims data relating to February and March are not available at the time the draft Annual Accounts are due for submission.

As a result, the Health Board has to accrue for the likely cost of drugs for this 2-month period and the cost of dispensing fees from Community Pharmacies and GP Dispensing practices. The methods of making these estimates are well established and applied consistently over many years. Few contractual changes have occurred over the last

decade that significantly affect the way payments to Primary Care Contractors are calculated and their timing. With this stability, it has been possible to build a consistent track record and reliable basis for making reasonable estimates.

### **Annual leave not taken by staff at year-end**

NHS Bodies must follow the Treasury's Financial Reporting Electronic Manual (FReM). This manual incorporates areas such as Generally Accepted Accounting Policies (GAAP), International Accounting Standard (IAS) and International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to public benefit entities.

Under IAS 19 the Health Board undertakes an annual leave pay accrual, reflecting unused paid annual leave that could be settled wholly before 12 months after the end of the reporting period. Therefore, an organisation allowing employees to carry forward annual leave this incurs a cost to the Health Board against its revenue funding.

Prior to the Covid-19 pandemic, it would generally be expected that staff would take annual leave entitlements progressively throughout the year and, with a few exceptions, there would be no need to carry over any unused entitlements. During COVID, and because staff could not necessarily take leave in the usual way, BCU built up a significant level of unused entitlements.

These unused entitlements in the 2022/23 Annual Accounts were represented through an accrual that was made for untaken leave entitlements of c£13 million (around 1.3% of annual staff costs, equivalent to around 5 average annual calendar days). This was based on entitlements for each individual staff member recorded in the Establishment Staffing Resource (ESR) system.

The policy for 2023/24 was confirmed at the start of the year and clarified that there would be a return to the pre-pandemic policy of no carried forward of annual leave (exceptional cases would be considered for staff on long term sickness or maternity leave, for example). The staff-side representatives have been involved in the decision and the revised policy has been reiterated on numerous occasions during the year and a further reminder notification issued on Betsinet:

- *As per normal terms and conditions there will be no carry-over of annual leave approved between leave years for staff on Agenda for Change or Executive and Senior Management contracts.*
- *Health Board annual leave entitlement periods run from April 1 to March 31, meaning all leave should be taken within that period in order to ensure staff have time away from work. Managers should work with colleagues to ensure their leave is taken within the annual leave period.*
- *For staff on Medical and Dental Contracts, where the leave year is not linked to the financial year, up to five days annual leave may be carried forward subject to an application and approval being given (again as per normal terms and conditions). That said, the guiding principle should be that all staff should take their leave entitlement in the year it relates to so as to refresh themselves.*
- *In exceptional circumstances where a staff member has been expressly prevented from taking their annual leave entitlement because of service needs or due to long term sickness then carry-over of leave may be authorised*

Underlying ESR data quality issues means the accrual involves a higher degree of judgement. Opportunities for improving the quality of underlying staff data records (ESR and e-Rostering) will continue to be identified and discussions will continue to be held between Finance and Workforce to progress improvement going forward.

The methodology used for calculating the 2023/24 Annual Leave Accrual will revert to the pre-pandemic approach:

- For Agenda for Change staff - identify the balances and calculate the value for staff who held a legal entitlement to carry leave over into the new year due to Sickness & Maternity.
- For Medical & Dental staff – select a sample and identify with the manager the entitlement to carry over. Using the sample, extrapolate the entitlement, and calculate a value.
- For frozen leave, these are calculated based on the actual entitlement of the staff who retain this right and who remain employed by the Health Board.

### **Medical Study Leave Accrual**

The British Medical Association website outlines the Medical Staff Terms and Conditions and states the recommended standard for professional and study leave entitlement. This information is provided for Non-training Grade posts (e.g., Consultants) and Training Grade Posts. However, the NHS Bodies may at their discretion grant professional or study leave above the period recommended standards detailed on the website.

Unlike the Annual Leave liability, where there is clear guidance in the FReM, there is no corresponding direction on the requirement to account for cover when medical staff take their study leave, beyond the basic accounting principles (accrual, provision or contingent liability) which determines how an item is reflected in the accounts. Across Wales there is no consistent assessment of the liability or a methodology for calculating an accrual.

At the end of each financial year there may remain unused Study Leave. Medical study leave however, does not run in Financial Years, which makes determining the value in days remaining at the 31<sup>st</sup> March an area of judgement. The level of accrual in the previous financial year was c £4 million and the Health Board is continuing to review this level of provision in production of the 2023/24 Annual Accounts.

### **Invoices on hold – “No Purchase Order No Pay”**

In line with NHS Wales policy, invoices received without a valid Purchase Order (PO) are not progressed for payment. The Health Board receives listings of invoices held, which have cumulated over time - these totalled c£4.4 million in the previous financial year. These invoices were across 474 suppliers.

As there is no quoted PO, there is no evidence from finance users that goods or services have been received to legitimise payment and, in many cases, insufficient information to identify where any potential legitimate commitment from within the Health Board may have originated.

Divisions will be asked to confirm whether they recognised any of the items on the listing. A small number are expected to be specifically recognised and confirmed as

accrued as legitimate commitments. In the previous financial year, for the balance of cumulative invoices, the Health Board made a general assumption that 15% of these may subsequently prove to be legitimate expenditure commitments and therefore accordingly accrued (£0.640 million). A review (for appropriateness) of the percentage to be used for the 2023/24 accrual is currently being undertaken and Audit Wales made aware of the resulting impact placed upon the Accounts.



<b>Teitl adroddiad:</b>	Internal Audit Plan 2024/25 – April to September 2024
<b>Report title:</b>	Internal Audit Progress Report 1 January to 29 February 2024
<b>Adrodd i:</b>	Audit Committee
<b>Report to:</b>	
<b>Dyddiad y Cyfarfod:</b>	15 March 2024
<b>Date of Meeting:</b>	
<b>Crynodeb Gweithredol:</b> <b>Executive Summary:</b>	<p>The audit plan for 2024/25 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.</p> <p>The internal audit plan for April to September 2024/25 details the risk based planned reviews for the first six months of the financial year following review of Board and Committee papers; Board Assurance Framework; Corporate Risk Register; risk based meetings with Independent Members and Executive Directors; and reviews deferred from 2023/24.</p> <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none"><li>• the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management.</li><li>• the Board and required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.</li></ul> <p>The progress report summarises three assurance reviews finalised since the last Committee meeting in January 2024, with the recorded assurance as follows:</p> <ul style="list-style-type: none"><li>• Substantial assurance (green) – one;</li><li>• Reasonable assurance (yellow) – none;</li><li>• Limited assurance (amber) – two;</li><li>• Unsatisfactory (red) – none; and</li><li>• Advisory (grey) – none.</li></ul> <p>The report also details the reviews with reports issued as draft and work in progress.</p>
<b>Argymhellion:</b> <b>Recommendations:</b>	<p>The Committee is asked to:</p> <p><b>Plan</b></p> <ul style="list-style-type: none"><li>• Approve the six-month Internal Audit Plan for April to September 2024.</li><li>• Note the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2024/25.</li><li>• Approve the Internal Audit Charter.</li><li>• Note the associated Internal Audit Key Performance Indicators.</li></ul> <p><b>Progress report</b></p> <ul style="list-style-type: none"><li>• Receive the progress report.</li></ul>
<b>Arweinydd Gweithredol:</b> <b>Executive Lead:</b>	Interim Board Secretary
<b>Awdur yr Adroddiad:</b> <b>Report Author:</b>	Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA

<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	<b>I'w Nodi</b> <i>For Noting</i> <input checked="" type="checkbox"/>		<b>I Benderfynu arno</b> <i>For Decision</i> <input checked="" type="checkbox"/>		<b>Am sicrwydd</b> <i>For Assurance</i> <input checked="" type="checkbox"/>
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>	
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b>					
The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan. The Health Board assurance ratings differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank.					
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>  <b><i>Link to Strategic Objective(s):</i></b>			N/A other than those relating to individual audit reviews / recommendations.		
<b>Goblygiadau rheoleiddio a lleol:</b>  <b><i>Regulatory and legal implications:</i></b>			The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.		
<b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b>			The Equality duty is not applicable.  This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).		
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>			The Socio-Economic duty is not applicable.  The audit plan for 2023/24 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.  This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).		
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesyfeirio at y BAF a'r CRR)</b>			N/A other than those relating to individual audit reviews/recommendations.		

<b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>	
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>  <b>Financial implications as a result of implementing the recommendations</b>	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>  <b>Workforce implications as a result of implementing the recommendations</b>	N/A other than those relating to individual audit reviews/recommendations.
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>  <b>Feedback, response, and follow up summary following consultation</b>	The internal audit plan and progress report is produced independently of management.  Internal Audit plan shared with both the Chief Executive and Interim Board Secretary for comment.  Progress report shared with the Interim Board Secretary.
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	N/A other than those relating to individual audit reviews.
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	N/A
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b>  <b>Next Steps:</b> <b>Implementation of recommendations</b>  The six month internal audit plan and progress report is presented in accordance with the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
<b>Rhestr o Atodiadau:</b>  <b>List of Appendices:</b> <ul style="list-style-type: none"> <li>• Appendix 1: Internal Audit Plan 2024/25 - April to September 2024</li> <li>• Appendix 2: Progress report</li> <li>• Appendix 3: Follow up – Delivery of Health Board Savings</li> <li>• Appendix 4: Water Safety</li> </ul>	

Internal Audit Plan 2024/25 – April  
to September 2024

Internal Audit Charter

March 2024

Betsi Cadwaladr University Health Board

## Contents

1.	Introduction .....	3
1.1	National Assurance Audits .....	3
2.	Developing the Internal Audit Plan .....	3
2.1	Link to the Public Sector Internal Audit Standards .....	3
2.2	Risk based internal audit planning approach .....	3
2.3	Link to the Health Board systems of assurance .....	5
2.4	Audit planning meetings .....	5
3.	Audit risk assessment.....	5
4.	Planned internal audit coverage .....	7
4.1	Internal Audit Plan 2024/25 (April to September 2024).....	7
4.2	Keeping the plan under review .....	7
5.	Resource needs assessment .....	7
6.	Action required.....	8
	Appendix A: Internal Audit Plan 2024/25 – April to September 2024 .....	9
	Appendix B: Audit Universe/Rolling Plan .....	15
	Appendix C: Key performance indicators (KPI) .....	30
	Appendix D: Internal Audit Charter.....	31



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

### Disclaimer notice - please note:

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

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

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

# 1. Introduction

This document sets out the six-month Internal Audit Plan for the period April to September 2024 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. The rolling internal audit plan includes other areas of risk at the time of development that will be assessed for the last six-months of the year. These were identified as part of the annual risk assessment but are not currently prioritised within the Internal Audit Plan coverage, some of these areas may be considered in future years plans.

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

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

Accordingly, this document sets out the risk-based approach, the first six-month Plan for April to September 2024 and the audit universe (rolling plan for the period 2019/20 to 2024/25). The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

## 1.1 National Assurance Audits

These audits are part of the risk-based programme of work for Digital Health and Care Wales (DHCW), NHS Wales Shared Services Partnership (NWSSP) and Cwm Taf Morgannwg University Health Board (for Welsh Health Specialist Services Committee (WHSSC and Emergency Ambulance Services Committee (EASC)) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

# 2. Developing the Internal Audit Plan

## 2.1 Link to the Public Sector Internal Audit Standards

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

## 2.2 Risk based internal audit planning approach

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

- the organisation's risk assessment and maturity.

- the organisation’s response to key areas of governance, risk management and control.
- the previous years’ internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

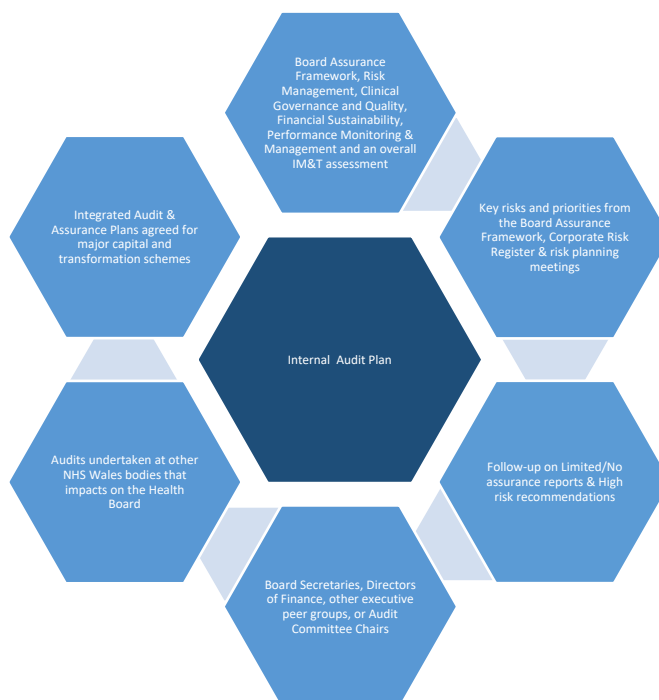
Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP), Living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

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

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

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

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



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

### 2.3 Link to the Health Board systems of assurance

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

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

### 2.4 Audit planning meetings

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

## 3. Audit risk assessment

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

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

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



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

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

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



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

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

- Strategic planning
- Healthcare commissioning and contract management
- Business continuity planning



## Financial Risks (*Financial Governance and Management*)

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

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



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

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

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



## Technology Risks (*Information Governance and Security*)

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

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



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

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

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



## Workforce Management Risks (*Workforce Management*)

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

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



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

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

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



## Property Risks (*Capital & Estates Management*)

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

- Fire safety management
- Asbestos management etc.

## 4. Planned internal audit coverage

### 4.1 Internal Audit Plan 2024/25 (April to September 2024)

The six-month Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings.

Where appropriate, the Plan makes cross reference to key strategic risks identified within the corporate risk register, related systems of assurance and outline scope. The scope, objectives and timing will be refined when developing the audit brief in discussion with the responsible executive director(s) and operational management.

The Audit Committee will be kept apprised of performance in delivery of the Plan through routine progress reports to each Audit Committee meeting.

The audit work will be undertaken by our regionally based team with support from our national Capital & Estates team, in terms of capital audit and from our Digital & IT team regarding Information Governance, IT security and digital work.

### 4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

The development of a six-month plan ensures we can focus on priority risk areas, business critical systems, and the provision of assurance to management across the year ahead. We will, as always, keep the plan under review to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan enabling us to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

## 5. Resource needs assessment

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

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

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource

requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

## 6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for April to September 2024/25 and:

- approve the six-month Internal Audit Plan for April to September 2024;
- note the Audit Universe/Rolling plan and the risks identified for consideration for October to March 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit Key Performance Indicators.

David Harries CMIIA QiCA

Head of Internal Audit – Betsi Cadwaladr University Local Health Board  
Audit & Assurance Services  
NHS Wales Shared Services Partnership

## Appendix A: Internal Audit Plan 2024/25 – April to September 2024

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
Corporate Governance and Regulatory			
<p><b>Corporate Legislative Compliance: Civil Contingencies Act 2004</b></p> <p>We will review the Health Board’s compliance with the Act as a Category 1 Responder.</p>	<p>SP 19</p> <p>Executive request</p>	<p>Board Secretary</p>	<p>April</p>
<p><b>Special Measures</b></p> <p>We will review progress and delivery against the five stated Outcomes and where relevant corroborate whether the actions have resulted in improvement.</p>	<p>CRR 24-16 Score 20</p>	<p>Director Transformation and Planning</p>	<p>May</p>
<p><b>Follow-Up of Internal Audit recommendations</b></p> <p>We will review the implementation of Limited assurance report recommendations not subject to full review and those defined as ‘High Risk’ in other reviews.</p>	<p>Standards compliance</p>	<p>Board Secretary</p>	<p>April to September</p>
Strategic			
<p><b>Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)</b></p>	<p>SP 18</p> <p>BAF SP 18 Score 25</p>	<p>Director of Nursing &amp; Midwifery</p>	<p>July</p>

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
<p>We will assess implementation of the management actions agreed as a result of the no assurance review in 2022/23.</p> <p><b>Transformation &amp; Improvement</b></p> <p>We will review how the Transformation and Improvement Team deliver on its purpose "<i>...to support and enable the organisation to transform and improve itself.</i>"</p>	SP 18	Director of Transformation and Planning	July
Financial			
<p><b>Charitable Funds (Deferred from 2023/24)</b></p> <p>We will review compliance with the Health Board's own procedures and a sample of Charity Commission guidance.</p> <p>We will also assess implementation of the management actions agreed as a result of the limited assurance review in 2022/23.</p>		Director of Finance & Performance	May
<p><b>Value Based Healthcare</b></p> <p>We will review the outcomes related to the Health Board investment of £3.1m in 2023/24 in Value Based Healthcare, including the Value Based Care Function, as detailed in the Financial Plan approved by the Board.</p>	SP 11	Director of Transformation and Planning	June

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
<p><b>Business Cases: Capital and Revenue</b></p> <p>We will review the Health Board’s compliance with its own procedure, reporting arrangements and whether post implementation reviews have been undertaken to ascertain if the stated benefits were achieved.</p>	<p>SP 16 CRR 24-05 Score 20</p>	<p>Director of Transformation and Planning</p>	<p>April</p>
Clinical governance, Quality and Safety			
<p><b>Quality Governance: Concerns and Complaints</b></p> <p>We will review compliance with expected controls and service provision across the Health Board.</p>	<p>SP 18 BAF SP 18 Score 25</p>	<p>Director of Nursing &amp; Midwifery</p>	<p>April</p>
<p><b>Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)</b></p> <p>We will review the Health Board implementation of Welsh Health Circulars (WHC) 2021/022 <i>Publication of the Quality and Safety Framework</i> and 2023/06 <i>Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020</i>.</p>	<p>SP 18 BAF SP 18 Score 25 CRR 24-04 Score 25</p>	<p>Director of Nursing &amp; Midwifery</p>	<p>June</p>
Technology			
<p><b>Intelligence led organisation</b></p>	<p>SP 13 BAF SP13 Score 20</p>	<p>Chief Digital and Information Officer</p>	<p>May</p>

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
<p>To review the capabilities in place, from a people, process and technology perspectives, for the Health Board to manage and transform its data to deliver the appropriate and accurate intelligence to inform better decisions.</p> <p><b>Network and Disaster Recovery</b></p> <p>To review the Health Boards processes for managing the IT Infrastructure and network, to ensure the appropriate enactment of resilience and fault domains to prevent disruption to services, and to ensure that disaster recovery plans enable rapid and focused recovery from disruptions.</p>	<p>SP 13 BAF SP13 Score 20</p>	<p>Chief Digital and Information Officer</p>	<p>August</p>
Operational service and Functional management			
<b>No specific risk identified for coverage in April to September 2024</b>			
Workforce management			
<p><b>People &amp; OD Strategy: Operational implementation (Deferred from 2022/23 &amp; 2023/24)</b></p> <p>Working with colleagues in People &amp; OD, we will review the delivery and progress by Health Communities, Regionally Managed Services and Service Support Functions in delivering the strategy.</p>	<p>SP 12 CRR 24-01 Score 16</p>	<p>Director of People &amp; OD</p>	<p>May</p>

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
<p><b>Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)</b></p> <p>We will assess implementation of both the management actions agreed as a result of the limited assurance review in 2022/23 and independent report commissioned under Special Measures.</p>	<p>SP 12 CRR 24-05 Score 20</p>	<p>Director of People &amp; OD</p>	<p>April</p>
<p><b>Establishment Control and Recruitment</b></p> <p>We will review the end-to-end process from creating a request to recruit through to appointment and verify whether the Health Board is complying with <i>Standing Financial Instruction 14.2 – Funded Establishment</i> and <i>14.3 – Staff Appointments</i>.</p>	<p>SP 12 CRR 24-05 Score 20</p>	<p>Director of People &amp; OD/Director of Finance &amp; Performance</p>	<p>July</p>
Project/Programme			
<p><b>Integrated Assurance and Approval Plans (IAAP)</b></p> <p>The following programme/project audits are scheduled to be progressed during 2024/25 (but will also be subject to any audit planning updates required at respective SOC/OBC/FBC submissions):</p> <ul style="list-style-type: none"> <li>Llandudno Hospital Orthopaedic Hub</li> </ul>	<p>BAF Risk 3.1 - score 16</p>	<p>Director of Finance &amp; Performance</p>	<p>April to September</p>

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
<ul style="list-style-type: none"> <li>Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit</li> <li>Ysbyty Maelor Wreccsam - Infrastructure/ Continuity Works</li> </ul>			
Property			
<p><b>Corporate Legislative Compliance: Fire Safety</b></p> <p>To assess compliance with the requirements of <i>Welsh Health Technical Memorandum (WHTM) 05-01: 'Firecode – Managing healthcare fire safety'</i>, which provides practical guidance in the application of statutory regulation in healthcare premises.</p>	<p>SP 14 CRR 24-06 Score TBD</p>	<p>Director of Finance &amp; Performance</p>	<p>May</p>

## Appendix B: Audit Universe/Rolling Plan

The review topics detailed is not an exhaustive list of all services/processes identified and some will reflect a whole system, upon which elements will be reviewed.

The ✓ in 2023/24 indicates we intend to provide assurance in this area. The R records an identified risk area for consideration as part of the next six-month plan (October to March). Due to the risk based approach and resources available, we will not undertake reviews in all those identified areas and the Committee/management may wish to ensure they have adequate second-line assurance reporting in place.

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
<b>Corporate governance, risk, and regulatory compliance</b>							
Welsh Language Measure (Wales) 2011	Limited			Limited	Reasonable		Ⓜ
Board Assurance Framework & Risk Management		Reasonable	Reasonable	Limited	x	Ⓜ	Ⓜ
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016					Ⓜ	Ⓜ	
Corporate Legislative Compliance - Equality Act 2010: Public Sector Equality Duty						Ⓜ	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
Corporate Legislative Compliance: Social Services and Well-being (Wales) Act 2014							
COVID-19 Governance & Associated reviews		Assurance not applicable*2	Assurance not applicable*2				
Corporate Legislative Compliance - Civil Contingencies Act 2004						✓	
Partnership governance	Limited		Limited		Ⓜ	Ⓜ	
Regional Partnership Board/Integrated Service Board			Limited				
Standards of Business Conduct - Declarations of interest, gifts, and hospitality			Limited		x	Ⓜ	Ⓜ
Board, Executive, Divisional Governance		Limited	Assurance not applicable	Limited		Ⓜ	
Operating Model					x		
Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation (SORD)				Reasonable	Ⓜ		
Policies & Procedures					Ⓜ	Ⓜ	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Targeted Intervention/Special Measures			Reasonable			✓	
Impact Assessments	Limited		Reasonable				
Welsh Risk Pool – Claims Management	Reasonable	Substantial					
Annual Report/Annual Governance Statement	Advisory	Advisory	Advisory	Advisory	Advisory	✓	✓
Preparations for EU Exit (BREXIT)		Assurance not applicable					
<b>Strategic risk</b>							
Performance management & Reporting		Reasonable		Limited	Ⓡ	Ⓡ	
Strategic planning - Including IMTP					Ⓡ		
Annual Operational Plan						Ⓡ	
Business Continuity Planning/Arrangements		Limited	Limited			Ⓡ	
Healthcare Commissioning						Ⓡ	
Transformation / Project Management				Assurance not applicable		✓	
Communication and Stakeholder engagement					Ⓡ	Ⓡ	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
<b>Financial risk</b>							
Asset management					Ⓡ		
Benefits Realisation					Ⓡ		
Budgetary Control & Financial reporting	Reasonable	Reasonable	Reasonable	Reasonable	x	Ⓡ	
Business Case - Capital and Revenue					Ⓡ	✓	
Accounts Receivable - Cash and Bank/Petty Cash/Cash receipting					Reasonable	Ⓡ	
Charitable Funds				Limited	Deferred	✓	
Costing							
Counter Fraud				Reasonable			
Financial planning/Sustainability							
General Ledger					Ⓡ	Ⓡ	
Lease Cars						Ⓡ	
Losses and Special Payments					Ⓡ		
Standing Financial Instructions - Procurement	Reasonable*2		Reasonable		Special Measures report Advisory	Ⓡ	Ⓡ
Private / Overseas Patients					Ⓡ	Ⓡ	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
Patients Monies and Property	Assurance not applicable	Assurance not applicable					
Payment Card Industry Compliance						Ⓜ	Ⓜ
Savings - Identification and Delivery		Limited		No	Limited	Ⓜ	
Stores						Ⓜ	
Value Based Healthcare				Assurance not applicable		✓	
Year-end processes					Reasonable		
<b>Clinical governance quality &amp; safety</b>							
Annual Quality Statement	Reasonable	Reasonable					
Clinical audit			Limited		Limited		
Clinical coding							
Clinical Commissioning - Quality & Safety				No	Deferred	✓	
Corporate Legislative Compliance: Health and safety at Work etc. Act etc. Act 1974	Reasonable	Assurance not applicable			Limited		
Corporate Legislative Compliance: Health and Social					Ⓜ	✓	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
Care (Quality and Engagement) (Wales) Act 2020							
Deprivation of Liberty Safeguards (DOLS)	Limited				x		
Decontamination	Limited					Ⓜ	
End of Life Care						Ⓜ	
Follow-up Healthcare Inspectorate Wales			Assurance not applicable			Ⓜ	
HASCAS & Ockenden Follow-up	Reasonable	Reasonable	Assurance not applicable				
Incident management							
Infection Prevention and Control					Ⓜ	Ⓜ	
Medical equipment and devices							Ⓜ
Nutrition and Hydration						Ⓜ	
Patient experience					Ⓜ	Ⓜ	
Patient Safety Notices etc		Reasonable					Ⓜ
Public Health				Reasonable		Ⓜ	
Concerns/Complaints/Putting things right/Learning Lessons			Reasonable		Limited	✓	
Quality Improvement Strategy	Limited				Ⓜ	Ⓜ	
Research and Development						Ⓜ	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Safeguarding	Substantial					Ⓡ	
Security		Limited	Assurance not applicable			Ⓡ	
Ward accreditation					Ⓡ	Ⓡ	
World Health Organisation (WHO) Checklist/Local Safety Standards for Invasive Procedures (LocSSIP)						Ⓡ	
<b>Technology</b>							
Informatics governance		Assurance not applicable					
Digital Strategy / Digital Operating model				Reasonable	Reasonable		Ⓡ
Digital readiness						Ⓡ	Ⓡ
Service Management (ITIL)					Ⓡ	Ⓡ	
Access Controls							
Identity and certificate management							
Cyber security	Reasonable		Reasonable		Substantial	Ⓡ	
Change Control							
Data analytics / Intelligence led organisation				Limited		✓	

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Business process automation / robotics					Ⓡ		
IT equipment / end user device management					Ⓡ	Ⓡ	
IT infrastructure / network management (inc. NIS Directive)			Reasonable		Ⓡ	✓	
IT Projects					Ⓡ		
Software / system development							
Disaster recovery and resilience		Limited				Ⓡ	
Cloud migration							
Medical records management, control, and access					x	Ⓡ	
Patient records & Digital Integration / digitisation					Substantial		
Safe Care							
Data quality							
Corporate Legislative Compliance: Freedom of information Act						Ⓡ	Ⓡ
GDPR	Reasonable						
Welsh IG Toolkit (inc. Caldicott)		Substantial		Substantial			

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Locally managed IT systems - Where control rests outside of DDaT					Ⓡ	Ⓡ	
Datix Web						Ⓡ	
IRIS						Ⓡ	
WOREQ2							
CWS							
E-expenses						Ⓡ	
Electronic Staff Record						Ⓡ	
Wellsky Pharmacy Management System					Ⓡ		
Oracle E-financials							
PACS & Radis							
Welsh Clinical Portal							
Welsh Demographic Service							
WPAS						Ⓡ	
<b>Operational service and functional management</b>							
Bereavement Services							
Integrated Health Community - Central			Assurance not applicable		x		

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Integrated Health Community - East				Limited		Ⓡ	
Integrated Health Community - West				Limited			Ⓡ
Cancer Services						Ⓡ	
Womens Services			Reasonable		x		
North Wales Managed Clinical Services							Ⓡ
Mental Health and Learning Disabilities	Assurance not applicable	Limited	Assurance not applicable	Reasonable	Limited		Ⓡ
Cluster management and development			Reasonable			Ⓡ	
Clinical Trials							
Discharge / Patient Flow management					x		
Continuing Health Care				Reasonable		Ⓡ	
Education							
Emergency Medical Retrieval and Transfer Service Cymru (EMRTS)							
Energy							
Falls Management					Limited	Ⓡ	
General Dental Services							Ⓡ

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
General Medical Services						Ⓡ	
General Ophthalmic Services							
GP Out of Hours					Limited		
Urgent Primary Care Centres (UPCC)				Limited		Ⓡ	
Looked After Children (LAC)						Ⓡ	
Managed GP Practices	Reasonable				Ⓡ	Ⓡ	
Medical Physics							
Non-Emergency Patient Transport Service	Reasonable						
Operational Estates and Facilities						Ⓡ	
Primary Care – Transformation Fund/Other							
Transport Management						Ⓡ	
Unscheduled care – Six Goals for Improvement					Ⓡ	Ⓡ	
Waiting list management			Limited		Ⓡ	Ⓡ	
Planned care delivery				Limited		Ⓡ	Ⓡ
Prison Healthcare Services							
NHS Wales Act - Section 33 Agreements	Limited					Ⓡ	
Veterans							
<b>Workforce management</b>							

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Agency Staffing/IR35		Limited			Ⓡ		
Annual leave							
Approved Clinicians and Section 12(2) approval		Reasonable					
Case Management & Disciplinary process					X		
Corporate Legislative Compliance: National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005					X		
Consultant Contract/Job planning						Ⓡ	
Consultant Revalidation						Ⓡ	
Staff Benefit Schemes							
Roster management		Limited	Limited		Ⓡ	Ⓡ	
Job evaluation							
Manual Handling						Ⓡ	
Medical Staffing			Reasonable				
NHS Wales Staff Survey	Limited					Ⓡ	
Occupational Health						Ⓡ	
On-Call			Limited			Ⓡ	
Payroll/Salary Overpayments	Limited						
PADRs							

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
People & OD Strategy					Deferred	✓	
Professional Registration					Ⓜ	Ⓜ	
Raising staff concerns/Safehaven/Speak out Safely				Reasonable		Ⓜ	
Recruitment/Establishment Control	Limited		Reasonable	Limited Substantial		✓	
Engagement of Interim appointments		Limited			Assurance not applicable	✓	
Sickness absence management					Ⓜ		
Staff Leavers			Limited				
Staff wellbeing							
Statutory and mandatory training							
Temporary Staffing							
Upholding Professional Standards in Wales (UPSW)			Reasonable				
Violence & Aggression		Limited				Ⓜ	
Voluntary Early Release Scheme (VERS)			Reasonable	Reasonable			
Volunteers							
Workforce Race Equality Standard (WRES)							Ⓜ

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓡ = Risks identified	Ⓡ = Risks identified
Waiting list initiative						Ⓡ	
<b>Project and programme risk</b>							
Integrated Audit Plans - Major capital schemes assurance	Reasonable*5	Reasonable		Reasonable	Reasonable Deferred	✓	Ⓡ
Discretionary funded schemes & equipment procurement					Ⓡ	Ⓡ	Ⓡ
Capital Systems		Reasonable	Substantial				
Vehicle, Equipment & IT Procurement	Assurance not applicable						
<b>Property</b>							
Corporate Legislative Compliance - Asbestos Management			Reasonable			Ⓡ	Ⓡ
Corporate Legislative Compliance - Fire Safety	Reasonable					✓	
Corporate Legislative Compliance - Water Safety		Limited			Limited	Ⓡ	
Medical Gases							
Electricity Safety Regulations					Ⓡ		Ⓡ
Backlog Maintenance							
Minor works							

Review topics	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25	2025/26
<b>ANNUAL OPINION</b>	<b>Reasonable</b>	<b>Reasonable</b>	<b>Limited</b>	<b>Limited</b>	X = Assurance reviews in progress	✓ = April - September Ⓜ = Risks identified	Ⓜ = Risks identified
Maintenance and operations							
Control of Contractors		Limited					
Waste Management			Reasonable			Ⓜ	
Residential Accommodation						Ⓜ	
Property management				Substantial	Ⓜ		
Carbon Reduction Commitment Order/Decarbonisation	Substantial			Advisory			
Environmental Sustainability	Reasonable	Substantial			Limited		
<b>Analysis of reviews</b>							
Substantial	2	3	1	3	2	0	
Reasonable	18	9	16	10	6	0	
Limited	10	12	9	11	9	0	
No assurance/Unsatisfactory	0	0	0	2	0	0	
Assurance not applicable/Advisory	3	7	8	4	4	0	
<b>TOTAL number of reviews</b>	<b>33</b>	<b>31</b>	<b>34</b>	<b>30</b>	<b>21<sup>1</sup></b>		

<sup>1</sup> Number of reviews at draft and final stage as of 13<sup>th</sup> February 2024

## Appendix C: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2023/24 agreed/in draft by 30 April	R	100%
Audit opinion 2022/23 delivered by 31 May	R	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	R	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	R	80%
Report turnaround management response to draft report [20 working days minimum]	R	80%
Report turnaround draft response to final reporting [10 days]	R	80%

## Appendix D: Internal Audit Charter

### 1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Betsi Cadwaladr University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
  - Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

### 2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Betsi Cadwaladr University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:
-

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

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

### 3 Independence and Objectivity

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

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

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

- 
- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
  - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited
  - 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
  - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

## 4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer, and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

---

private meetings with the Head of Internal Audit.

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

## 5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the NHS Digital Health and Care Wales, Wales Shared Services Partnership, WHSSC and EASC.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

## 6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards, and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

## 7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
  - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
  - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
  - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
  - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
  - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
  - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
  - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

## 8 Approach

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

**Figure 1: Audit planning hierarchy**

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

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

- 
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:
- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
  - audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
  - improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
  - an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
  - effective co-operation with external auditors and other review bodies functioning in the organisation; and
  - the allocation of resources between assurance and consulting work.
- 8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.
- 8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.
- 8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.
- 8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.
- 8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.
- 8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the
-

---

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

## 9 Reporting

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

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

9.2 The process for audit reporting is summarised below:

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

- 
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow- up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

## 10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

## 11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

## 12 Quality Assurance

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

- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

## 13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

## 14 Review of the Internal Audit Charter

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

Simon Cookson  
Director of Audit & Assurance  
NHS Wales Shared Services Partnership  
February 2024



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

Betsi Cadwaladr University Local Health Board

# Audit Committee Internal Audit Progress Report

1<sup>st</sup> January to 29<sup>th</sup> February 2024

NWSSP Audit and Assurance Services

## Contents

Introduction	3
Reports Issued	3
Work in Progress Summary	7
Contingency/Organisational Support/Advice	8
Delivering the Plan	8



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

### Disclaimer notice - please note:

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

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

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

## Introduction

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

## Reports Issued

2. Since the last progress report, four reviews have been finalised in conjunction with Health Board management and two issued as draft. A summary of the finalised reviews is provided in Table 1.

## Executive Summaries

Follow up – Delivery of Health Board Savings BCU-2324-16

18 January 2024

Report opinion: Limited







**Purpose:** To establish progress made by management to implement agreed actions arising from the previous internal audit report (BCU-2223-15), which concluded no assurance over the arrangements in place for the identification and delivery of savings as outlined in the IMTP and associated Financial Plan for 2022/23.

### Overview

Progress has been made to address the majority of the previous report findings, although the delivery of recurring savings remains a significant challenge, with reliance again on transactional savings being the norm. The significant matters which require management attention include:

- It is not clear why £37.8m in undelivered recurring savings for 2022/23 were funded in 2023/24. This undermines and discourages any motivation for all operational and corporate functions to deliver cash releasing savings.
- Transformational change savings were again not evident and no review has been undertaken on the role of the Transformational Team; this must be progressed as a priority.
- In relation to Voluntary Early Release Scheme savings, management have not actioned six of the business case savings despite it being approved by the Remuneration and Terms of Service Committee. We are concerned that management have acted without authority in not implementing the decision of the Committee.
- Clarity on changes between the Financial Plan approved by the Board in March 2023, with a savings requirement of £30m, and the current savings requirement of £25.2m, is needed to ensure the Committee/ Board are sighted on changes in-year, coupled with receiving assurance on the £13.5m disinvestment savings and if/where these have been achieved.
- The establishment of the Executive Improvement Delivery Group encompassing both performance and finance is positive, although it lacks a specific focus on future pipeline transformational savings. This is a key limitation in turning around the financial challenge facing the Health Board and must be addressed with some urgency in advance of the 2024/25 financial year.

## Progress Summary

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

Water Safety

BCU-2324-13

6 February 2024

Report opinion:

Limited



**Purpose:** To consider whether there are robust processes and controls in place within the Health Board to ensure compliance with the Policy for the Management of Safe Water Systems (ES02) and Welsh Health Technical Memorandum 04-01 – Safe water in healthcare premises.

**Overview**

The matters requiring management attention include:

- There is poor attendance / clinical representation at Local and pan Health Board Water Safety Group Meetings
- Ward areas and departments do not provide assurance that flushing of little used outlets is completed in line with policy.
- There is a lack of training provision in respect of water hygiene / microbiological control and competency assessment for staff whose responsibilities directly impact water safety.
- It is not clear whether risk assessments adequately assess the risk of Pseudomonas or whether the assessment is solely of Legionella. There is no formal process to ensure risk assessments are reviewed within specified timescales.
- There is a lack of assurance from water providers regarding testing and quality of contingency plans.

Objectives	Assurance
1 The Health Board has robust management and governance arrangements in place to support compliance with the Welsh Health Technical Memorandum 04-01 requirements. Water safety is subject to Board or Committee level oversight and scrutiny.	Reasonable
2 The Health Board has robust monitoring and reporting arrangements in place to safeguard patients, staff and other stakeholders. This includes appropriate inspection / detection regimes, data retention and dissemination, and staff training provision.	Limited
3 The Health Board has robust Water Safety risk management arrangements in place to manage and mitigate relevant risks.	Limited

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

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1 Pan-BCU and Local Water Safety Group meetings are poorly attended by certain staff groups (notably clinical representatives).	1	Operation	Medium
2 Ward and department managers are not providing assurance or evidence to the Operational Estates Department that they are flushing little used outlets per Water Safety Plan / SOP requirements. However, it is also not clear whether staff are aware of their responsibilities regarding flushing.	2	Operation	High
3 Staff outside of Operational Estates have not received water hygiene, microbiological control, Legionella awareness, or other relevant water safety training appropriate to the task they are responsible for conducting.	2	Design	High
4 It is not clear whether risk assessments adequately assess the risk of Pseudomonas or whether the assessment is solely of Legionella. Management tracking does not record date of assessment / planned review date therefore there is a risk that assessments will not be reviewed per Water Safety Plan requirements.	3	Design	High

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
5 The Health Board does not have an overarching Business Continuity Plan for loss of mains water supply and does not receive assurance from water providers that their contingency plans are robust and routinely tested.	3	Design	High

CITO Programme

BCU-2324-29

29 February 2024

Report opinion:

Substantial



**Purpose:** To ensure that there is appropriate programme governance in place for the CITO programme (a programme to deliver a Clinical Document Repository with eForm functionality).

### Overview

There is a formal governance structure for the CITO Programme which includes scope and initiation documentation Programme Board and regular reporting of the status of the programme. There are plans in place for delivery of the programme objectives and there is a process for stakeholder engagement, along with actions to improve the engagement processes.

Testing of the architecture was undertaken, and test stages are built into project plans and work packages, which include user acceptance testing.

The matter requiring management attention is:

- Establish the level of commitment of resource for CITO for future phases and adjust the programme aims accordingly.

### Objectives

### Assurance

1 Control and Governance	Substantial
2 Delivery Plans	Reasonable
3 Stakeholder Engagement	Substantial
5 Testing	Substantial

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

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1 Resource provision - there is a lack of resource that is impacting on the delivery of some of the programme phases, and whilst programme reporting is clear about this, there is an ongoing risk that CITO will not be able to be fully delivered.	2	Operation	Medium

## Work in Progress Summary

3. The following draft reports have been issued:

Table 1 - Draft Reports issued

Review	Status	Date draft report issued	Management response due
Health & Safety	A management response has been received, however we were unable to agree to the actions for three recommendations. Management are reviewing these.	23 January 2024	20 February 2024  (received 19 February 2024)
Follow up review	Draft issued to Office of the Board Secretary for review.	29 February 2024	Not applicable

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

Table 2: Reviews in progress

Review	Draft report due:
Effective Governance: Womens	March 2024
Effective Governance: Central IHC	March 2024
Operating Model	March 2024
Follow up of Internal Audit Recommendations	Ongoing - report as required
Discharge Arrangements – Discharge to Recover then Assess (D2RA) Pathways	March 2024
Corporate Legislative Compliance: NHS (Appointment of Consultants)	April – delayed due to receiving information from management

Review	Draft report due:
(Wales) (Amendment) Regulations 2005.	
Standards of Business Conduct	March
Budgetary Control	March – delayed due to management agreement of brief
Deprivation of Liberty Safeguards	March
Risk Management	March / April
Grievance management	April
Records Management – Fragmented Care records	April
Orthopaedic Surgical Hub Llandudno Hospital	March

### Contingency/Organisational Support/Advice

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

### Delivering the Plan

- The additional support provided to the Health Board with focused reviews is channelled through contingency.
- As new risks are identified in year, the Board Secretary and internal audit 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) with the assurance provided.
- Table 3 is reporting a positive status across all indicators. Figures are based on nineteen reports/briefing papers issued as final (or requiring no response) to date.

Table 3 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal	Green	84%	80%	v>20%	10%<v<20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
Audit Charter and Service Level Agreement]						
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%

Table 4 – Core Plan 2023-24 (April 2023 to March 2024)

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

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
	2023		
Follow up - Welsh Language Commissioner - Documents on the Website	August 2023	Final report issued.	Reasonable
Health and Safety	October 2023	Draft report issued.	Limited
Digital Health Record (Cito) – Patient Records Transition Programme	November 2023	Final report issued.	Substantial
Follow up of Internal Audit Recommendations	October 2023 – March 2024	Draft report issued.	Not applicable
Effective Governance - Integrated Health Community – Central	October 2023	Review in progress.	
Discharge arrangements / patient flow management	October 2023	Review in progress.	
Operating model	November 2023	Review in progress.	
Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality	December 2023	Review in progress.	
Womens Services	November 2023	Review in progress.	
Corporate Legislative Compliance: NHS Appointment of Consultant Regulations 2005	November 2023	Review in progress.	
Budgetary Control	December 2023	Review in progress.	
Deprivation of Liberty Safeguards (DoLS)	January 2024	Review in progress.	
Risk Management	February 2024	Review in progress.	
Records Management – Fragmented Care records	February 2024	Review in progress.	
Grievance management	February 2024	Review in progress.	
Wrexham Maelor Continuity	October 2023 – March 2024	Deferred.	
Workforce Strategy: Operational implementation (Deferred from 22/23)	June 2023	Deferred.	
Follow up - Recruitment of substantive and interim	December 2023	Deferred.	

---

<b>Planned output</b>	<b>Outline timing</b>	<b>Status</b>	<b>Assurance (including draft report assurance opinions)</b>
executive and senior posts			
Charitable Funds	January 2024	Deferred.	
Follow up – Contracted Patient Services: Quality and Safety arrangements	January 2024	Deferred.	

## Audit Assurance Ratings

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

	<p><b>Substantial assurance</b></p>	<p>Few matters require attention and are compliance or advisory in nature.  <b>Low impact</b> on residual risk exposure.</p>
	<p><b>Reasonable assurance</b></p>	<p>Some matters require management attention in control design or compliance.  <b>Low to moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>Limited assurance</b></p>	<p>More significant matters require management attention.  <b>Moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>Unsatisfactory</b></p>	<p>Action is required to address the whole control framework in this area.  <b>High impact</b> on residual risk exposure until resolved.</p>
	<p><b>Assurance not applicable</b></p>	<p>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.</p>

# Follow-up: Delivery of Health Board savings

## Final Internal Audit Report

January 2024

Betsi Cadwaladr University Health Board



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



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



## Contents

Executive Summary .....	3
1. Introduction.....	5
2. Findings .....	5
Appendix A: Status of Previous Matters Arising .....	7
Appendix B: Management Action Plan.....	14
Appendix C: Assurance opinion and action plan risk rating .....	21

Review reference:	BCU-2324-16
Report status:	Final Internal Audit Report
Fieldwork commencement:	7 November 2023
Fieldwork completion:	29 November 2023
Draft report issued:	30 November 2023
Debrief meeting:	22 November 2023 & 12 December 2023
Management response received:	4 & 12 January 2024
Final report issued:	18 January 2024
Auditors:	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit
Executive sign-off:	Russell Caldicott, Interim Executive Director of Finance
Distribution:	Andrea Hughes, Interim Finance Director Joanna Garrigan, Finance Director Phil Meakin, Interim Board Secretary
Committee:	Audit Committee



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

### Acknowledgement

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

### Disclaimer notice - please note

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

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

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

## Executive Summary

### Purpose

This review has sought to establish progress made by management to implement agreed actions arising from the previous internal audit [report BCU-2223-15 refers], which concluded no assurance over the arrangements in place the identification and delivery of savings as outlined in the IMTP and associated Financial Plan for 2022/23.

### Overview of findings

Progress has been made to address the majority of the previous report findings, although the delivery of recurring savings remains a significant challenge, with reliance again on transactional savings being the norm.



It is not clear why £37.8m in undelivered recurring savings for 2022/23 were funded in 2023/24. This undermines and discourages any motivation for all operational and corporate functions to deliver cash releasing savings.

Transformational change savings were again not evident and no review has been undertaken on the role of the Transformational Team; this must be progressed as a priority.





In relation to Voluntary Early Release Scheme savings, management have not actioned six of the business case savings despite it being approved by the Remuneration and Terms of Service Committee. We are concerned that management have acted without authority in not implementing the decision of the Committee.

Clarity on changes between the Financial Plan approved by the Board in March 2023, with a savings requirement of £30m, and the current savings requirement of £25.2m, is needed to ensure the

### Follow-up Report Classification

		Trend
 <p>Limited</p>	<p><b>Follow up: Progress</b> Three recommendations have progressed however more work is need to fully address the findings. One recommendation has had no action taken.</p>	

### Progress Summary

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

Committee/Board are sighted on changes in-year, coupled with receiving assurance on the £13.5m disinvestment savings and if/where these have been achieved.

The establishment of the Executive Improvement Delivery Group encompassing both performance and finance is positive although it lacks specific focus on future pipeline transformational savings. This is a key limitation in turning around the financial challenge facing the Health Board and must be addressed with some urgency in advance of the 2024/25 financial year.

We have concluded **limited** assurance overall.

---

## 1. Introduction

1.1 The original internal audit *Delivery of Health Board Savings* review was undertaken in December 2022 and considered whether the Health Board had delivered the requirements outlined in its Financial Plan for 2022/23.

The Financial Plan detailed a requirement of £35m recurring savings consisting of £18m Transactional and £17m Transformational savings.

1.2 At the outset of our review we noted the delivery of recurring savings was a significant risk to the Health Board achieving financial balance and found that the 2022/23 Month 5 Finance Report presented to the Health Board meeting on the 29th September 2022 (Item 22.233) advised the Board that "Savings delivered in the 5 months to August 2022 was £6.5 against a plan of £7.5m, a shortfall of £1.0m. Non-recurrent savings delivered are £2.4m. The savings forecast is £14.4m, which is £20.6m behind the target of £35m for the year. There were no transformation savings either planned or delivered in the first five months of the year."

We concluded no assurance for the review.

1.3 The original review identified four high priority matters arising:

- a) Reports to the Health Board did not reflect the complete savings required for 2022/23, inclusive of unachieved previous year recurring savings carried over – the monthly budget reports however included the unachieved savings from 2021/22.
- b) Voluntary Early Release savings had not been actioned in line with Remuneration and Terms of Service Committee approval.
- c) Governance and oversight arrangements in delivery of savings were not adequate.
- d) Transformational savings had not been identified.

1.4 The potential risks considered in the original review were:

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

1.5 The review was limited to the evidence provided to demonstrate completion of the agreed management actions.

## 2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations.

Previous Matter Arising	Original Priority Rating	Number of Recommendations	Implemented/ Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
1	High	1		1	
2	High	1		1	
3	High	1		1	
4	High	1			1
Total		4	0	3	1

2.2 Full details of current findings and implementation status are provided in **Appendix A**.

## Appendix A: Status of Previous Matters Arising

Previous Matter Arising 1: Board reporting (Design)		
Original Recommendation		Original Priority
The finance monthly Board report details the full recurring savings requirement with the IMTP ensuring it details the complete recurring savings in its savings plan, inclusive of all unachieved recurring savings carried over.		<b>High</b>
Original Management Response	Target Date	Responsible Officer
All monthly reporting of the overall finance position and of savings delivery will be against the savings target in the agreed financial plan and associated IMTP. The savings target for the year within the financial plan will take into account unachieved savings from the previous year and the requirement for savings in the plan year, but also the deliverability of savings. 1.3a Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website and resolve issues with delayed translation requests.	Reporting 2023/24 from April 2023	Interim Executive Director of Finance
Current findings		
<p>The 30 March 2023 Health Board meeting received and considered the Initial Financial Plan for 2023/24 that reported <i>Savings targets of £30m, equating to 2% of controllable budgets, have been allocated to divisions, based on £15.6m of core savings (1.25% of controllable budgets) and £14.4m relating to cross cutting themes (0.75% overall)</i>. Further content identified that the Health Board needed to deliver £38.7m in financial improvement, noted as follows:</p> <ul style="list-style-type: none"> <li>• Savings and cost pressure reduction -18.2</li> <li>• Disinvestment identified -13.5</li> <li>• Stretch target for further financial improvement -7.0</li> </ul> <p>Review of both the monthly report to Board/Committee and Welsh Government Monitoring Return has consistently reported a savings target of £25.2m, excluding a stretch savings target of £7m (per the Financial Plan).</p>		

We have found differences in the figures reported in the Financial Plan and current 23/24 finance reports and we have not been able to follow through Board/Committee papers the audit trail in reporting the changes:

- Finance reports record a stretch target of £5.7m against the original £7m detailed in the Financial Plan.
- A £30.9m savings requirement in the Finance reports against a £30m target per the Financial Plan, with reference also to £38.7m financial improvement target. The Financial Plan records a dis-investment saving of £13.5m but we can find no reference in the monthly finance reports whether these have been achieved following a Quality Impact Assessment or remain a savings pressure.

We reviewed the 2022/23 unachieved cash releasing recurrent savings and noted this totalled £37,888,523, bringing a total savings requirement excluding the stretch target of £7m for 2023/24 to £63,088,523 (unachieved savings plus £25.2m savings target reported). We were advised that the former Interim Executive Director of Finance agreed to "...agreed to fund the undelivered savings from 2022/23."

We saw two tranches of funding being allocated to fund the unachieved saving from 2022/23: *Funding for Undelivered recurrent savings in 22/23 £22,658,000* and a later adjustment of *£15,145,418 noted as an Adjustments to the B/fwd 22/23 CRES* – There remains an outstanding carry over balance of £85,105.

We have been unable to find anywhere in the Financial Plan the intention for the unachieved savings to be funded and can find no reference that this was approved by the Board.

**Conclusion: Partially implemented: Action ongoing, further action required – See Matter Arising 1 in Appendix B.**

Previous Matter Arising 2: Voluntary Early Release (VERS) recurring savings (Operation)		
Original Recommendation		Original Priority
The Executive Director of Finance ensures all approved VERS applications are acted on in accordance with the requirements of the Remuneration and Terms of Service Committee, with budget and establishment adjusted accordingly.		<b>High</b>
Original Management Response	Target Date	Responsible Officer
Agreed	Immediate	Interim Executive Director of Finance
Current findings		
<p>We reviewed email correspondence between Officers in the Finance Department for the period 29 March 2023 to 11 April 2023 inclusive with the subject "VERS 22/23 - Action required ahead of M12" and "APPROVAL REQUIRED BY TUESDAY 11TH (AM): VERS 22/23". The correspondence provided a summary of the posts (officers initials) and the VERS savings for action. Extracts from the correspondence note the following:</p> <ul style="list-style-type: none"> <li>• 29 March 2023: "At a glance, see that (Officer) saving totals £74k. Recall that (Officer) asked you to recalculate based on replacement at 8b level. (Officer) and (Officer) should agree the scheme before submission; (Officer) can decide whether he wants to pursue approval from Operational Leads."</li> <li>• 6 April 2023: Interim Executive Director of Finance approves the 'VERS PID' documentation - "I am happy with this....I think its right to have (Officer) as the lead - assume that's ok (Officer)?"</li> <li>• 11 April 2023: The Deputy Director of People approves the scheme - "That's fine (Officer)" in response to the email of 6 April 2023 outlining the requirement to approve the saving scheme by the 11 April 2023.</li> </ul> <p>We also reviewed the journal effecting the changes considered, approved and required by the Remuneration and Terms of Service Committee (RaTS) in line with the VERS business cases and recurrent savings/establishment changes approved.</p> <p>The review identified that management have not actioned all the VERS applications, with the following identified:</p> <ul style="list-style-type: none"> <li>• Finance Department – One Band 8c post was to be removed, however the former Interim Director of Finance is noted as stating the post was to fund an 8b replacement. This is not in accordance with the RaTS approval - £74,052 recurring saving not actioned.</li> </ul>		

- Mental Health and Learning Disabilities Division – One Band 8d post was to be removed, but was not actioned. This is not in accordance with the RaTS approval - £115,695 recurring saving not actioned.
- IHC Centre – Two posts received VERS with the limited savings identified following re-investment in the revised operating model structure. This is not in accordance with the RaTS approval - £44,058 recurring saving not actioned.
- IHC East – One post received VERS with the limited savings identified following re-investment in the revised operating model structure. This is not in accordance with the RaTS approval - £14,130 recurring saving not actioned.
- IHC West - One post received VERS with the limited savings identified following re-investment in the revised operating model structure. This is not in accordance with the RaTS approval - £13,000 recurring saving not actioned.

A total of £260,935 VERS approved business case recurrent savings have not been actioned in line with RaTS Committee approval. We are unable to confirm where the decision was taken to not implement these business cases recurrent savings/establishment change in line with RaTS Committee instructions.

**Conclusion: Not Implemented – See Matter Arising 2 in Appendix B**

Previous Matter Arising 3: Matter Arising 3: Effective governance and oversight arrangements to deliver savings (Design)		
Original Recommendation		Original Priority
The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes.		<b>High</b>
Original Management Response	Target Date	Responsible Officer
Agreed.	Immediate	Interim Executive Director of Finance
Current findings		
<p>We reviewed agenda and minutes of the <i>Executive Delivery Group - Performance and Finance</i> on the 16 August 2023 which do not evidence a focus on delivery of savings schemes.</p> <p>On the 20 September 2023 we noted that the meeting had changed title to <i>Executive Delivery Integrated Performance Group</i> with its Terms of Reference, presented at the meeting notes the following:</p> <p>2.3. <i>The following standard agenda shall be adopted:</i></p> <p>2.3.2. <i>Report on savings delivery by location and include specific reference to Cross Cutting Theme Executive Lead on progress to date:</i></p> <ul style="list-style-type: none"> <li>(a) <i>CHC</i></li> <li>(b) <i>Prescribing</i></li> <li>(c) <i>Managed Practice overspends</i></li> <li>(d) <i>Nurse Workforce</i></li> <li>(e) <i>Medical Workforce</i></li> <li>(f) <i>Unscheduled Care</i></li> <li>(g) <i>Planned Care</i></li> <li>(h) <i>Corporate Review</i></li> </ul>		

In further reviewing the 20 September 2023 agenda and the Savings report Month 5, we found no focus on those areas detailed in section 2.3.2 of the Terms of Reference. Further, there is no apparent focus in the Delivery Group on transformational savings/change which we note through Board and Committee reports as the biggest challenge to the Health Board achieving financial balance. In reviewing papers and Terms of Reference, we found the Group appears reactive as opposed to realising opportunities for service enhancement resulting in both performance and financial improvements.

We requested the agenda and draft minutes for the October 2023 meeting on the 8 November 2023 from the Head of Corporate Office but have not received a reply at the time of this report.

We sought to evidence where assurance from the Delivery Group progresses through the management structure and found that the Terms of Reference note the following, but we have been unable to corroborate whether this is happening:

8.1. *The IPG Chair shall:*

8.1.1. *Report formally via the Chairs' Assurance Report regularly and on a timely basis to the Executive Leadership.*

The review of the Performance Finance and Information Governance Committee papers at the November 2023 meeting noted the Month 6 savings Executive summary stating "... *The proportion of recurring Green savings now totals £14.1m. The shortfall against £25.2m therefore totals £11.1m.*" and as such do not consider this recommendation has been fully implemented.

**Conclusion: Partially implemented: Action ongoing, further action required – See Matter Arising 3 in Appendix B**

Previous Matter Arising 4: Transformational Savings and the establishment of the Transformational Team (Operation)		
Original Recommendation	Original Priority	
<p>The Health Board:</p> <ul style="list-style-type: none"> <li>• Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings.</li> <li>• Reviews the role of the Transformational Team in driving service change and savings.</li> </ul>	<b>High</b>	
Original Management Response	Target Date	Responsible Officer
Agreed.	April 2023	Interim Executive Director of Finance
Current findings		
<p>The Performance, Finance and Information Governance Committee (PFIG) meeting on 2 November 2023 received agenda item <i>PF23/142 Finance report - month 6</i> that contained several appendices including <i>PF23.142d Appendix B - Savings Summary Month 6</i>. We found the following statements within the papers presented and through discussions and review of savings schemes have been unable to confirm any transformational savings have been achieved at the time of this review.</p> <p><b>Appendix B - Savings Summary</b></p> <p><i>Executive Summary</i></p> <p><i>However, the common message continues to be that major savings require transformational change, which requires support and resource.</i></p> <p><i>Next Steps</i></p> <p><i>IHC's and Services continue to report that transformation is required to unlock significant benefit.</i></p> <p><i>Improvement Groups were established to deliver incremental, transformational savings.</i></p> <p>At the time of the review and following discussion, we have been advised that there has been no review of the Transformational Team role in taking forward and supporting service change within the Health Board.</p> <p><b>Conclusion: Not Implemented – See Matter Arising 4 in Appendix B</b></p>		

## Appendix B: Management Action Plan

Matter Arising 1: Board reporting of savings and changes in year from the Financial Plan	Impact
<p>The Health Board has consistently reported a savings target of £25.2m in both its reports to Board/Committee and Monitoring Return to Welsh Government (excluding an additional stretch savings target of £5.7m).</p> <p>The Financial Plan recorded a £30m savings target with a £7m stretch target. In addition the Financial Plan stated that the Health Board needed to achieve a £38.7m financial improvement, that included disinvestment of £13.5m – We have found no specific reporting on how these are being achieved, if at all.</p> <p>There was unachieved recurring cash releasing savings of £37,888,523, bringing a total savings requirement excluding the stretch target of £7m for 2023/24 to £63,088,523. We were advised that the former Interim Executive Director of Finance agreed to "...agreed to fund the undelivered savings from 2022/23."</p> <p>We saw two tranches of funding being allocated to fund the unachieved saving from 2022/23: one for 22,658,000 and a later adjustment of £15,145,418 with an outstanding carry over balance of £85,105 – We have found no reference in the Financial Plan that there was an intention to clear unachieved savings from previous years or that this was endorsed and agreed by the Board.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Incomplete information provided to the Board to make informed decisions</li> </ul>
Recommendations	Priority
<p>The Executive Director of Finance:</p> <ul style="list-style-type: none"> <li>• Ensures the Financial Plan outlines and recommends all proposed actions relating to unachieved savings for the Board to consider and approve.</li> <li>• Ensures any decision to fund undelivered cash releasing savings is formally approved by the Health Board.</li> <li>• Provides a full audit trail to Committee/Board of the savings requirement for 2023/24 to include the following:             <ul style="list-style-type: none"> <li>○ Where/what changes have happened between the Financial Plan (£30m) and current reported savings (£30.9m).</li> <li>○ What the 'Stretch Target' is and how it has reduced from £7m to £5.7m and the likelihood of it being achieved.</li> <li>○ Evidence of how the £13.5m Dis-investments have been achieved and how this is reported.</li> </ul> </li> </ul>	<p><b>High</b></p>

Agreed Management Action	Target Date	Responsible Officer
<p>As stated, the Health Board from July of the 2023/24 financial year has consistently reported the need to deliver £25.2m of savings (in Board papers of the 30<sup>th</sup> March and 22<sup>nd</sup> June reported as £18.2m plus £7m). The additional savings stretch, to increase the target was reported to Board on the 30<sup>th</sup> March, with the final stretch target £30.9m, which has been reported at Board and Committees during 2023/24.</p> <p>The £7m reported as stretch in the June 2023 report was incorrectly labelled as stretch, this was part of the original plan that made up the total ask of £25.2m for 2022/23. The stretch element totals £5.7m and was contained within the plan, the total targeted savings of £30.9m therefore the resultant value for savings contained within the plan.</p> <p>The movement represented by the £30m to £30.9m totalling £0.9m relates to an error in the reporting of the position within the plan update presented to members, the reported position should have totalled the £30.9m (breakdown described above).</p> <p>The £13.5m of dis-investments has been identified within the financial plans and will be shared with Audit colleagues, with a clear trail reported to PFIG in regards to these costs being removed alongside the budgeted planned reductions.</p> <p>The historic unachieved savings were clearly part of the brought forward underlying deficit in all reports to the Board. The Covid dis-investments related to 2022/23 reserves that had been previously held for the Health Board response to the pandemic. The Financial Plan removed the previous pressure from the opening position, with no further monitoring of delivery required.</p> <p>Significant progress has been made in refreshing the guidance documents for Divisions submitting Savings Plans. The current position shows that the regular beat of check and challenge sessions with Divisions combined with targeted leadership in this area of work, has resulted in the target being achieved by Month 8. The acknowledgement of the strength</p>	<p>31<sup>st</sup> March 2024</p>	<p>Executive Director of Finance (interim)</p>

of the financial monitoring systems and robust control spreadsheets is welcomed. The following is agreed moving forwards;

- Treatment of underachievement of prior year Savings will form an explicit element of future financial plan endorsement.
- As has occurred for 2023/24, the savings performance will be measured against the targeted delivery set at commencement of the financial year within endorsed plans.
- Any diss-investment referenced within the financial plans will be aligned to specific developments and the budget removed accordingly, with cost variance against the residual budgets identified within the financial reporting.

Matter Arising 2: Voluntary Early Release – Recurring Savings		Impact
<p>The Remuneration and Terms of Service Committee approved two rounds of applications submitted by the Executive for consideration and approval, collectively totalling £622,691 of recurring savings. Our review has found that management have not actioned six posts approved by Committee, totalling £260,935, summarised as follows:</p> <ul style="list-style-type: none"> <li>• Finance Department - £74,052 recurring saving not actioned.</li> <li>• Mental Health and Learning Disabilities Division - £115,695 recurring saving not actioned.</li> <li>• IHC Centre - £44,058 recurring saving not actioned.</li> <li>• IHC East - £14,130 recurring saving not actioned.</li> <li>• IHC West - £13,000 recurring saving not actioned.</li> </ul>	<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Breach of Standing Financial Instruction 14.1.5</li> </ul>	
Recommendations		Priority
<p>The Executive Director of Finance ensures all approved VERS applications are acted on in accordance with the requirements of the Remuneration and Terms of Service Committee, with budget and establishment adjusted accordingly.</p>		<p><b>High</b></p>
Agreed Management Action	Target Date	Responsible Officer
<p>The financial impact associated with any decisions presented through to the Remuneration Committee will be shared on a monthly basis with the Executive Director of Finance. Decisions taken enacted in accordance with the governance of the Health Board with any queries over implementation raised with the Health Board Secretary for confirmation at a subsequent meeting of the Remuneration Committee.</p>	<p>31<sup>st</sup> January 2024</p>	<p>Board Secretary</p>

Matter Arising 3: Effective governance and oversight arrangements to deliver savings		Impact
<p>The Executive had established an Executive Delivery Group - Performance and Finance (August 2023) with a name change noted for the September 2023 meeting to Executive Delivery Integrated Performance Group with a Draft Terms of Reference presented at the meeting.</p> <p>Whilst recognising its establishment the review of agenda, papers and proposed Term of Reference, there is limited focus on the fundamental issue in identifying, driving and supporting all operational and corporate services to achieve recurring transformational service change to improve both service quality and recurring savings.</p> <p>We found elements of the Terms of Reference were not being achieved and there was a reactive review on financial performance instead of driving future opportunities to realise transformational change and resultant savings.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Breach of Section 175 National Health Service Finance (Wales) Act 2014</li> </ul>
Recommendations		Priority
<p>The Executive review the Terms of Reference of the Executive Delivery Integrated Performance Group to ensure it includes a strong focus on savings to include service change to drive both quality improvement and recurrent financial savings.</p>		<p><b>High</b></p>
Agreed Management Action	Target Date	Responsible Officer
<p>Whilst savings delivery performance is reported within the newly formed ED – IPG, the Terms of Reference for the committee to be reviewed for consideration of specific reference to savings delivery, to include performance against target (recurrent and non-recurrent achievement). This will include specific reporting of performance against identified transformation and improvement opportunities across the Health Board.</p>	<p>28<sup>th</sup> February 2024</p>	<p>Executive Director of Finance (Interim)</p>




Matter Arising 4: Transformational Savings and Transformational Team review		Impact
<p>Management have not undertaken any action to address the original recommendation – it is restated for management action.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Breach of Standing Financial Instruction 4.3.4</li> </ul>	
Recommendations		Priority
<p>The Health Board:</p> <ul style="list-style-type: none"> <li>Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings.</li> <li>Reviews the role of the Transformational Team in driving service change and savings.</li> </ul>		<p><b>High</b></p>
Agreed Management Action	Target Date	Responsible Officer
<p><b>Recommendation 1: Opportunities</b></p> <p><b>The following is an up to date summary of the narrative that has been consistently supplied in relation to this recommendation:</b></p> <p>The purpose and role of the Transformation and Improvement team has always been to support and enable the organisation to transform and improve itself. It’s the only way it works, as change that is centrally generated and driven never sticks as it is not created and owned locally by the front line teams. As part of Special Measures, there is a deliverable (#5.4 – now complete) that is around ensuring that the Transformation and Improvement resource is allocated to support the priority areas. It has been agreed that the Portfolio Office continues supporting the central Special Measures coordination and the Improvement and Pathways resource allocated to the Interim Exec Director of Operations and Exec Director of Public Health (MHL) portfolios. The focus of their work is specified to be driven by these teams to support the organisation’s priorities. To date they have prioritised areas of service improvements relating to the highest areas of concern within</p>	<p>31st March 2024</p>	<p>Executive Director of Transformation, Strategic Planning and Commissioning</p>

<p>Special Measures. The Executive Delivery Group for Transformation and Strategic Planning provides oversight of this allocation with a specific remit to ensure that allocations remain aligned with organisational transformational priority.</p> <p><b>Propose that options to discharge are brought to the Executive Team for consideration and action.</b></p>		
<p><b>Recommendation 2: Role of Transformational Team</b></p> <p>As per the narrative associated with recommendation 1 above, this has been the subject of a deliverable as part of Special Measures. This is marked as complete with strong documentation and evidence to support the process applied and approach taken.</p> <p><b>Propose that this recommendation is therefore marked as complete and closed.</b></p>	<p>31st March 2024</p>	<p>Executive Director of Transformation, Strategic Planning and Commissioning</p>

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

### Audit Assurance Ratings

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

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

### Prioritisation of Recommendations

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

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

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



NHS Wales Shared Services Partnership  
4-5 Charnwood Court  
Heol Billingsley  
Parc Nantgarw  
Cardiff  
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

# Water Safety

# Final Internal Audit Report

## February 2024

## Betsi Cadwaladr University Health Board

## Contents

Executive Summary.....	3
1. Introduction.....	5
2. Detailed Audit Findings .....	6
Appendix A: Management Action Plan.....	16
Appendix B: Assurance opinion and action plan risk rating .....	23

Review reference:	BCUHB-2324-13
Report status:	Final
Fieldwork commencement:	20 October 2023
Fieldwork completion:	13 December 2023
Debrief meeting:	Debrief correspondence sent 13 December 2023
Draft report issued:	13 December 2023
Management response received:	5 February 2024
Final report issued:	6 February 2024
Auditors:	Rhys Jones, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Russell Caldicott, Interim Executive Director of Finance
Distribution:	Richard Daniel, Interim Director of Capital & Estates Arwel Hughes, Head of Operational Estates Phil Meakin, Interim Board Secretary
Committee:	Audit Committee



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

### Acknowledgement:

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

### Disclaimer notice - please note:

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

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

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

## Executive Summary

### Purpose

The review has considered whether there are robust processes and controls in place within the Health Board to ensure compliance with the Policy for the Management of Safe Water Systems (ES02) and Welsh Health Technical Memorandum 04-01 - Safe water in healthcare premises.

### Overview



We have issued limited assurance on this area.

The matters requiring management attention include:

- There is poor attendance / clinical representation at Local and pan-Health Board Water Safety Group Meetings.
- Ward areas and departments do not provide assurance that flushing of little used outlets is completed in line with policy.
- There is a lack of training provision in respect of water hygiene / microbiological control and competency assessment for staff whose responsibilities directly impact water safety.
- It is not clear whether risk assessments adequately assess the risk of Pseudomonas or whether the assessment is solely of Legionella. There is no formal process to ensure risk assessments are reviewed within specified timescales.
- There is a lack of assurance from water providers regarding testing and quality of contingency plans.

Other recommendations / advisory points are within the detail of the report.

### Report Opinion

		Trend
	<p><b>Limited</b> More significant matters require management attention.</p> <p><b>Moderate impact</b> on residual risk exposure until resolved.</p>	 2020/21

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

Objectives	Assurance
1 The Health Board has robust management and governance arrangements in place to support compliance with the Welsh Health Technical Memorandum 04-01 requirements. Water safety is subject to Board or Committee level oversight and scrutiny.	Reasonable
2 The Health Board has robust monitoring and reporting arrangements in place to safeguard patients, staff, and other stakeholders. This includes appropriate inspection / detection regimes, data retention and dissemination, and staff training provision.	Limited
3 The Health Board has robust Water Safety risk management arrangements in place to manage and mitigate relevant risks.	Limited

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

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority	
1	Pan-BCU and Local Water Safety Group meetings are poorly attended by certain staff groups (notably clinical representatives).	1	Operation	Medium
2	Ward and department managers are not providing assurance or evidence to the Operational Estates Department that they are flushing little used outlets per Water Safety Plan / SOP requirements. However, it is also not clear whether staff are aware of their responsibilities regarding flushing.	2	Operation	High
3	Staff outside of Operational Estates have not received water hygiene, microbiological control, Legionella awareness, or other relevant water safety training appropriate to the task they are responsible for conducting.	2	Design	High
4	It is not clear whether risk assessments adequately assess the risk of Pseudomonas or whether the assessment is solely of Legionella. Management tracking does not record date of assessment / planned review date therefore there is a risk that assessments will not be reviewed per Water Safety Plan requirements.	3	Design	High
5	The Health Board does not have an overarching Business Continuity Plan for loss of mains water supply and does not receive assurance from water providers that their contingency plans are robust and routinely tested.	3	Design	High

## 1. Introduction

- 1.1 The Health Board has responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulations 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water (i.e. with regard to Legionella, Pseudomonas aeruginosa and other water borne pathogens) to patients, visitors, staff and other persons working at or using its premises.

The Welsh Health Technical Memorandum (WHTM) 04-01 gives comprehensive advice and guidance to healthcare management, design engineers, estate managers, operations managers, contractors and the supply chain on the legal requirements, design applications, maintenance and operation of hot and cold-water supply, storage and distribution systems in all types of healthcare premises.

The Health Board is committed to reducing the risks associated with water borne pathogens and ensuring compliance with WHTM 04-01 by providing arrangements to ensure effective practice, through the Policy for the Management of Safe Water Systems (ES02).

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

- Adverse impact on patient, staff, and stakeholder safety.
- Ineffective / inappropriate governance and risk management arrangements.
- Failure to comply with regulations.
- Prosecution / criminal negligence leading to fines and defence costs.
- Adverse publicity and reputational damage.

- 1.3 Limitation to scope – we are unable to verify that key documents relating to Water Safety (Water Safety policy and Water Safety Plan) fully conform with relevant legislation and Welsh Health Technical Memorandum (WHTM) 04-01 due to the technical nature of the field. However, we are advised that external expertise was provided by the Authorised Engineer – Water (NWSSP Specialist Estates Services) who is a member of the Water Safety working group.

- 1.4 This report is based upon the information provided by the Head of Operational Estates, Area Responsible Persons – Water, Area Deputy Responsible Persons – Water, and information available in the public domain. We would like to express our gratitude to colleagues in for their input during the undertaking of the review.

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

---

## 2. Detailed Audit Findings

**Objective 1: The Health Board has robust management and governance arrangements in place to support compliance with the Welsh Health Technical Memorandum 04-01 requirements. Water safety is subject to Board or Committee level oversight and scrutiny.**

### Policy

2.1 Water Safety management and governance requirements are documented in the Health Board policy ES02: Policy for the Management of Water Systems. The policy, which is available online on BetsiNet, was approved in May 2022, activated in January 2023, and will be due for review in May 2025. The purpose of the document as defined in the policy is as follows:

*"The purpose of this policy is to state the corporate philosophy and approach to the management of water systems by defining how the BCUHB will identify and manage as far as reasonably practical the risk of exposure that could arise from Legionella, Pseudomonas aeruginosa or other water borne pathogens by stating the overarching Policy supporting local procedural documents relating to Water Management arrangements in each of its properties".*

2.2 The policy details the following:

- Roles and responsibilities
- Management arrangements
- Escalation arrangements
- Implementation arrangements
- Requirements regarding the management of specific equipment
- Applicable legislation and standards

To support operational processes and ensure compliance with WHTM 04-01 and ES02: Policy for the Management of Water Systems, the Health Board has also established a Water Safety Plan. The Plan sets out how the risks from microbiological hazards associated with the supply and use of water are assessed, understood, managed, and controlled for buildings within the BCU estate.

The Plan also provides readers with a single point of access to a range of key documents relating to the management of Water Safety, including Terms of reference for Water Safety Group and Local Water Safety Groups, flushing procedure, Pseudomonas aeruginosa sample collection & testing procedure, and procedure for interruption in local water authority supply.

### Water Safety Group

2.3 In compliance with Welsh Health Technical Memorandum 04-01 (Parts A and B) the Health Board has established a pan-BCU Water Safety Group which is supported by three area (East, Central, and West) Local Water Safety Groups. WHTM 04-01 Part B defines the role of the Water Safety Group as follows:

---

*"The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP. The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols."*

2.4 Local Water Safety Groups meet bi-monthly and escalate issues of significance to the pan-BCU Water Safety Group (also held bi-monthly, though staggered), which in turn reports to the Health Board Strategic Infection Prevention Group. We confirmed that the Water Safety Groups have terms of reference in place outlining the role, remit, responsibilities, membership, and reporting requirements for the Group. We reviewed a sample of minutes and noted the following:

- Meeting minutes aren't always recorded - a sample of minutes from each of the three Local and pan-BCU Water Safety Group meetings was provided for review, however only one area (West) provided copies of three most recent consecutive meetings. Management confirmed at the outset that not all meetings were minuted citing staffing issues and work pressures as the limiting factor, however we are advised that escalation reports and local updates were presented to the Water Safety Group following each Local WSG meeting.
- Local Water Safety Group meetings are not consistently attended by all members of the Local Area Water Management Control Team – none of the meetings reviewed had full membership attendance per the terms of reference. We found that a significant number of apologies were received with no nominated deputy attending on their behalf. Concern over meeting attendance and specifically a lack of Clinical and Facilities representation at Local Water Safety Group meetings has been escalated to the pan-BCU Water Safety Group. We confirmed that this was discussed at the November Water Safety Group meeting and that an action point was raised to address the issue. However, we also noted that that pan-BCU Water Safety Group also has similar attendance issues, with members / services consistently failing to attend the meeting and not sending representatives.
- We confirmed that the Health Board Strategic Infection Prevention Group (SIPG) has a term of reference (v7.3 May 2023) in place that outlines its responsibilities regarding the Water Safety Group. The Head of Operational Estates (also Chair of the Water Safety Group) submits the Monthly Report for Items for Escalation Only to the Strategic Infection Prevention Group highlighting issues of significance from the Water Safety Group. We reviewed the SIPG minutes for July, August, and September 2023 and noted the following references to water safety:
  - "Water flushing issue compliance with policy and potential legionella risk" - recorded in the July meeting minutes as an issue for escalation.

- “Arwel (Hughes) requested ward and department managers ensure they were aware of their responsibilities for water safety and the management of little used outlets” - recorded in the August meeting minutes as an issue for escalation.
- Escalation to the Board and its Committees is via the Strategic Infection Prevention Group which report to the Health Board Quality, Safety and Experience Committee (QSE). We reviewed a sample of published QSE minutes and found the following:
  - Legionella management and control is included on the Health Board corporate risk register (CRR20-03), which is reviewed at QSE Committees. Lack of training, awareness and understanding of legionella, and lack of assurance for the management of water systems at ward / departmental levels was highlighted in the July and August 2023 committees. However, this level of detail is not included in the revised consolidated Corporate Risk Register report presented to the October QSE Committee.
  - A water safety update, including a summary from the NHS Wales Shared Services, Special Estates Services Authorising Engineer (Water) Annual Report, was included in the Infection Prevention and Control Annual Report (2022-23) submitted to the August 2023 Committee.

### Conclusion:

2.5 The Health Board has established governance arrangements to support the management of Water Safety and ensure compliance with Welsh Health Technical Memorandum 04-01. Processes, procedures, and responsibilities are fully documented and are subject to local, Board / Committee, and external (via NWSSP Shared Services, Special Estates Services Authorising Engineer (Water)), review, oversight, and scrutiny. Forums and routes of escalation are in place, however poor attendance / representation at Local and pan-BCU Water Safety Group meetings limit the effectiveness of the Groups in fulfilling their remit.

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

**Objective 2: The Health Board has robust monitoring and reporting arrangements in place to safeguard patients, staff, and other stakeholders. This includes appropriate inspection / detection regimes, data retention and dissemination, and staff training provision.**

#### Monitoring, reporting, and inspection / detection regimes

2.6 Water system monitoring, reporting, inspection / detection regimes, and testing schedules are specified in the Health Board Water Safety Plan. We reviewed arrangements in place and noted the following:

#### Planned Preventative Maintenance (PPM)

- 
- Health Board Planned Preventative Maintenance (PPM) function for water systems has been outsourced to Clearwater Technology. The scope of works (per the Contract Specification) includes the following:
    - Completion of water safety risk assessments and schematic drawings, including specific assessment for augmented care area (carried out by SafeCare – see 2.19).
    - Annual cleaning and disinfection of all water storage cisterns.
    - Quarterly cleaning and disinfection / replacement of showerheads and hoses.
    - Monthly temperature monitoring of domestic hot and cold water sentinel outlets and annual representative monitoring.
    - Monthly temperature monitoring of Calorifier/Cylinder/Plate Heat Exchangers (PHE) gas fired water storage heaters, POU water heaters in accordance with Table 1 of WHTM 04-01 Part B.
    - Inspection of Domestic hot water cylinders/Calorifiers, PHE, gas fired water storage heaters in accordance with Table 1 of WHTM 04-01 Part B.
    - Six monthly in-service testing of Thermostatic Valves (TMV) in accordance with WHTM 04-01 Performance Specification DO8 2017 edition.
    - Annual inspection, cleaning, de-scale and disinfection of any strainers or filters associated with TMV's.
    - Six monthly Inspection, flush and purge to drain of expansion vessels.
  - Clearwater's responsibilities include all water maintenance testing, temperature monitoring, failsafe testing, and annual service of TMVs.
  - Testing schedules and results of testing are reported via an online portal which is accessed and reviewed by the Estates team. Fails, defects, results that fall outside specified ranges, or issues of significance are flagged on the system. We are advised that Clearwater will also notify the Estates team directly if they come across any issues that require immediate action, e.g. cylinder not working. The Estates team use the portal to inform their job planning / work allocation. Once the allocated work has been completed, Estates team leaders are required to update the portal and upload supporting evidence to demonstrate issues have been resolved.
  - The Estates team hold monthly meetings with senior representatives from Clearwater to review performance and raise concerns / issues of significance. We are advised that the meetings are formally recorded, however no copy minutes were provided for review.

#### Pseudomonas aeruginosa and Legionella testing

- Pseudomonas aeruginosa and Legionella are routinely tested every six months in augmented care areas. Testing in all other areas is undertaken

based on risk, notification of issue / concern, testing data, and / or area development. Water samples are collected by operational Estates staff and sent to the Public Health Wales Microbiology Department based in Ysbyty Gwynedd for analysis. For negative results, the Department issue result certificates that are retained. Positive results are subject to escalation protocol with relevant departments notified (Operational Estates, Infection Prevention Team, and Health Board Microbiologist) and copies of the laboratory results report shared.

- Operational Estates maintain spreadsheets (provided for review) to manage and track *Pseudomonas aeruginosa* and *Legionella* testing results and have established processes to address outlets that have yielded positive results. Example practices include removing / decommissioning the affected outlet, flushing, cleaning and re-testing, and / or fitting and monitoring point of use filters.

#### Flushing of little used outlets

- The flushing of little used outlets located outside of ward / clinical areas and departments is managed by the Operational Estates team. We confirmed that each area maintains a register of little used outlets and undertake twice-weekly flushing, which is signed-off on completion. Flushing records are retained, and copies were provided for review. The flushing sheets reviewed were generally well-maintained, however we did note the following exceptions relating to the sign-off of flushing in West community hospitals (Ysbyty Penrhos Stanley, Bryn y Neuadd, and Llandudno General Hospital). In the examples provided the Estates staff have not signed off completion of flushing against each individual outlet listed appropriately – exceptions include unsigned sheets, bulk sign-off (i.e. single date and signature), signing and dating the first entry only and using ditto marks or arrows to confirm the flushing of other outlets.
- Department managers are responsible for water safety in ward / clinical areas and departments. Responsibilities and requirements are defined in the Health Board Water Safety Plan with detailed instructions provided in the established Standard Operating Procedure (SOP) for the Management of Little Used Outlets. The Water Safety Plan states that,

*"All ward / department managers managing a specific area, have a responsibility to ensure the requirements of the WSP are carried out for requirements under their control... Department Managers shall have documented procedures in place that ensure the water used in clinical areas is safe and prevents adverse health effects to patients, staff and members of the public. Key procedures shall be in place relating to use of water and water systems that apply to all clinical boards."*

Defined responsibilities over flushing include the following:

- Ward/Department Managers are responsible for identifying the little used outlets and risk assessing the ongoing need for the outlet.

- Ward/Department Managers are responsible for ensuring the flushing regime is performed, documented and reported. Little used outlets should be flushed daily in defined augmented care areas, and twice weekly in all other areas.
- The Flushing Log will be kept at ward / department level and retained for a minimum of 2 years.
- The Flushing Log book should be e-mailed to the Operational Estates Department (Helpdesk E-Mail Address) on a weekly basis.
- We sought to review operational compliance however were advised that Operational Estates do not receive any assurance from wards and departments that they are maintaining flushing duties. Wards and departments do not confirm flushing activities or submit flushing records / log books to the Operational Estates departments per the SOP. Estates officers also stated that they request flushing records when visiting wards and departments (e.g. where an outlet has tested positive for Legionella) and found that practice and flushing activities varied significantly.
- Facilities, hotel services cleaning / domestic staff also support flushing regimes. Duties and responsibilities, including flushing, are outlined in Domestic Standard Operating Procedure (SOP) for Sanitary Cleaning (included as appendix in Water Safety Plan). Assurance of flushing / cleaning is not provided to Operational Estates department however we acknowledge that this is not a specified requirement in the Water Safety Plan / Standard Operating Procedure (SOP) for Sanitary Cleaning.

### Training

2.7 Training and competency requirements are outlined in the Health Board Water Safety Plan. All BCU Responsible Person(s) – Water and Deputy Responsible Person(s) – Water, are required to attend and successfully pass a two-day Responsible Person Training course and assessment every two years to ensure their knowledge and skills are maintained. The training course (The Role of the Responsible Person and Water hygiene in Healthcare Facilities in Accordance with HTM04-01) is a City and Guilds Accredited Programme and is facilitated by ClearWater, though is also available from other third-party providers. We sought assurance that staff were up to date with their training requirements and found the following:

- Central – A register of course attendance was provided for review and showed that the Responsible Person – Water and both Deputy Responsible Persons – Water, had attended the training course during May and July 2023 (following initial completion in 2021). The training course had also been attended by other key Estates staff involved with water systems.
- East – Training certificates for Deputy Responsible Persons – Water were provided for review. The certificates were dated July 2021, and were therefore overdue for renewal (like Central other key staff involved with water systems had also attended and passed the course in 2021 and 2022).

The Estates Officer (East) stated that attendance of an equivalent course (offered by an external supplier) was planned for February 2024.

- West – Estates Officer (West) advised that all staff had completed the relevant training course however were now due for renewal. No evidence of completion or copy certificates were provided for review.
- Other training - In addition to the mandatory course above we are advised that the Estates team had secured a free training course (Water Regulation Training) from Dŵr Cymru which has recently been attended by West and Central staff (East plan to attend in the New Year). Also, all mechanical craftsmen working with water must complete Competent Person training and Water Regulation (Legionella Awareness in Hot and Cold Water Systems and Water Hygiene in Healthcare Facilities in Accordance With HTM04-01) training. A register of completed Competent Person training course dates was provided by the Central team, whilst the East team provided copy certificates – as with the Responsible Person training East team training had been completed in 2021 therefore was due for renewal.

2.8 Water safety competence and training requirements are mandated for Responsible Person(s) – Water, Deputy Responsible Person(s) – Water, and mechanical craftsmen working with water systems. However, Legionella / Pseudomonas awareness and Water Safety training is not mandatory for other Health Board staff whose responsibilities and duties directly impact water safety (e.g. ward and department managers, domestic staff). Policy dictates that staff will be given instruction and training on the reasons for and how to carry out the required duty, however it is not clear what training should / will be provided, or how compliance will be measured.

*"All staff that work for BCUHB have a role to play in the safe use of water systems and in the management and control of the risk of Legionella, Pseudomonas aeruginosa and other water borne pathogens... Where necessary they shall receive adequate instruction and training to perform their duties effectively." - ES02: Policy for the Management of Water Systems.*

*"All staff whose duties include the identification and flushing of little used outlets shall be given suitable instruction on the reasons for and how to carry out the required duty"... The competence of persons shall be assessed from time to time in accordance with their allocated duties, and where necessary additional training and instruction provided – BCUHB Water Safety Plan.*

#### Conclusion:

2.9 The Health Board Operational Estates Department has processes and controls in place to monitor water system inspection / detection regimes and manage remedial work to address defects / non-conformance. Ward and department managers, and facilities staff have a significant role in maintaining water safety through routine flushing, however no assurance is provided to the Operational Estates Department that flushing tasks are undertaken and documented per the Water Safety Plan and Standard Operating Procedure (SOP) for the Management of Little Used Outlets.

2.10 The Health Board is not meeting the requirements of Welsh Health Technical Memorandum 04-01 – Safe water in healthcare premises Part B regarding training and competence assessments. Whilst Responsible Person(s) – Water and craftsmen working with water systems training and competencies are mandated and monitored, there is no formal training provision or requirements (e.g. Water Hygiene / Legionella awareness etc), or competence assessments, for other staff groups that have direct duties and responsibilities impacting water safety (ward and department managers, facilities staff etc).

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

**Objective 3: The Health Board has robust Water Safety risk management arrangements in place to manage and mitigate relevant risks.**

Risk assessments

2.11 The requirements and responsibilities regarding the undertaking, management, and review of water system risk assessments are defined in ES02: Policy for the Management of Water Systems and the BCU Water Safety Plan. Per the Water Safety Plan, the Health Board have commissioned independent external consultants, SafeCare (a consultancy division of WCS Group), to undertake the water system risk assessments.

2.12 SafeCare commenced work on risk assessing all Health Board water systems during 2021, producing individual bespoke risk assessments for each ward, area, and department reviewed. Completed risk assessments comprise the following:

- Executive summary
- Site water services register
- Site air services register
- Risk assessment – amplification potential
- Risk assessment – population susceptibility potential
- Risk assessment – management control
- Overall risk rating
- Priority rated action plan to address defects / non-compliance
- Appendices comprising guidance on compliance, assessment findings, backing information (including photographic evidence), reporting schedules, plant survey data, and a system schematic

2.13 Examples of completed risk assessments were provided for review. Whilst comprehensive it is not clear whether the scope of the assessments address risks pertaining to *Pseudomonas aeruginosa*. The narrative used in the assessments make specific references to *Legionella* throughout (the assessments are titled “*Legionella* Risk Assessment of Hot & Cold Water Systems in Healthcare Premises”), however management believe that the scope extends beyond this. BS 8580-2: 2022 Water quality - Risk assessments for *Pseudomonas aeruginosa* and other waterborne pathogens - Code of Practice British Standards Institution, is

---

referenced as a source employed in undertaking the assessment however Management should clarify this to ensure that risks from *Pseudomonas aeruginosa* are formally assessed in accordance with the Water Safety Plan and WHTM 04- 01 *Pseudomonas aeruginosa* - advice for augmented care units.

2.14 Area Estate Officers have established processes to capture and track implementation of risk assessment action plan recommendations / addressing identified defects or non-conformities. We reviewed working practice and noted the following:

- The process for managing risk assessments varies by area. Risk assessments are discussed at Local and pan-BCU Water Safety Group meetings.
- East – all action plan recommendations have been collated onto a single spreadsheet arranged by ward / area. Provision is included for progress notes, priority, and status. A report on implementation progress is submitted to the Local Water Safety Group for scrutiny.
- West – spreadsheets are used to track and monitor implementation. Spreadsheets comprise separate tab for each ward / area with action plan recommendations extracted from relevant risk assessments. There is provision to record status against each recommendation, however whilst there are some examples of progress notes or relevant job numbers recorded, many of the cells remain empty. We cannot determine from the tracking spreadsheets whether risk assessment recommendations have been implemented / actioned.
- Central – a summary area risk assessments is recorded on a spreadsheet register. Action plan recommendations are managed manually and recorded in a log book. Each risk assessment is printed and retained. Required actions / improvements are allocated to works staff – once complete, work is signed off, and the action is updated on the printed copy risk assessment and evidence of work undertaken is retained on file.
- We are advised that the overall risk rating for patient occupied areas would always be high or very high, regardless of amplification potential and management controls, due to the health issues and very high susceptibility of a large proportion of the site's occupants.
- There is no formal process in place to review risk assessments in compliance with the timescales specified in the Water Safety Plan - "*Risk assessments shall be formally reviewed to ensure they remains up to date no less often than every 2 years, or whenever there is reason to suspect that they are no longer valid*" (for *Legionella* and *Pseudomonas*). We acknowledge that the risk assessments remain open / live as the teams implement action plan recommendations / address defects and non-conformities, however the systems used to track implementation has no provision to record the date that risk assessment was undertaken and date of next review. Each of the three area Estate Officers stated that they would request a new risk assessment for any ward or area subject to major changes or developments.

### Contingency planning

2.15 ES02: Policy for the Management of Water Systems outlines escalation requirements and provides contact details for each area's water supplier (Dŵr Cymru - Central and West, and Hafren Dyfrdwy Cymru - East). However, the Health Board does not have formal overarching contingency plans for loss of mains water supply (though it is considered within some service specific Business Continuity Plans / Business Impact Assessments). We are advised that both suppliers have contingency plans / Emergency Response Action Plans in place to ensure continued supply - using a rolling supply of tankers to feed the system via hydrant connection points (management confirmed that these are routinely tested and flushed). However, no assurance is provided to the Health Board regarding the quality or testing of contingency plans.

### Conclusion:

- 2.16 The Health Board has arrangements in place to manage and mitigate relevant risks, though there is scope to improve the consistency in how risk assessment recommendations are managed and tracked across the Health Board. There is currently no formal process in place to ensure risk assessments are reviewed in compliance with the timescales stated in the Water Safety Plan. We acknowledge that the completed risk assessments are comprehensive, however management must ensure that the risk assessments also adequately assess risks from *Pseudomonas aeruginosa*.
- 2.17 The Health Board does not have an overarching Business Continuity Plan for site-wide loss of water supply and relies on water provider contingency plans / Emergency Response Action Plans. However no assurance is provided to the Health Board regarding the quality or testing of these plans.

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

## Appendix A: Management Action Plan

Matter Arising 1: WSG/LWSG meeting attendance (Operation)		Impact	
<p>We reviewed pan-BCU Water Safety Group and Local Water Safety Group meeting attendance per recorded minutes and found the following:</p> <ul style="list-style-type: none"> <li>Pan-BCU Water Safety Group and Local Water Safety Group meetings are not consistently attended by all members of the group.</li> <li>None of the meetings reviewed had full membership attendance per the terms of reference.</li> <li>A significant number of apologies are received for the meetings with no nominated deputy attending on their behalf.</li> <li>Meetings often lacked representatives from clinical areas.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Water Safety Group unable to fulfil remit.</li> <li>Decisions made without appropriate representation.</li> <li>Lack of awareness and dissemination of key messages to relevant staff.</li> </ul>	
Recommendations		Priority	
1.1	All members must make every reasonable effort to attend. Where this is not possible a nominated Deputy should attend in his/her place.	<b>Medium</b>	
1.2	Management to formally review meeting attendance and escalate persistent issues of non-attendance / representation to relevant Executive leads.	<b>Medium</b>	
Agreed Management Action		Target Date	Responsible Officer
1.1	Present report at Strategic Infection Prevention Group and circulate Audit Report to all members of both Pan BCUHB Water Safety Group and Local Water Safety Group to highlight the importance of their attendance at the future meeting and ensure a deputy is allocated to the meeting in their absence.	26/01/2024	Director of Nursing Infection Prevention and Decontamination Head of Operational Estates

1.2	The lack of clinical attendance at Local Water Safety Group will be escalated as part of the Pan BCUHB Water Safety Group Meetings 'matters for escalation' to the Strategic Infection Prevention Group with a request for it to be escalated to the Quality Delivery Group which is chaired by an executive.	29/03/2024	Head of Operational Estates (Chair of Water Safety Group)
-----	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------	-----------------------------------------------------------

<b>Matter Arising 2: Flushing of little used outlets (Operation)</b>		<b>Impact</b>
<p>We reviewed the management of flushing of little used outlets and found the following limitations:</p> <ul style="list-style-type: none"> <li>• Ward and department managers are not providing any assurance or evidence of flushing to the Operational Estates Department.</li> <li>• Responsibilities and duties regarding the flushing of little used outlets is documented in the Water Safety Plan and relevant SOP, however we cannot verify that all relevant staff have seen, read, and understood the documents, and are aware of their responsibilities.</li> <li>• Some flushing sheets were not appropriately signed-off by Estates staff.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Contamination impacting patient and staff safety.</li> <li>• Failure to comply with policy requirements.</li> <li>• Staff not aware of their responsibilities.</li> </ul>
<b>Recommendations</b>		<b>Priority</b>
2.1	Management ensure flushing duties are undertaken and recorded per SOP for the Management of Little Used Outlets / Water Safety Plan. Weekly logs / evidence to be submitted to Operational Estates Department for review.	<b>High</b>
2.2	Management to engage with clinical areas / department to promote Water Safety Plan / SOP and ensure staff are aware of, and understand, their responsibilities regarding flushing / water safety.	<b>High</b>
2.3	Management ensure flushing list signed-off appropriately.	<b>Medium</b>

Agreed Management Action	Target Date	Responsible Officer
<p>2.1 Re-issue the SOP at Strategic Infection Prevention Group and highlight the importance of document and request that all wards and departments are reminded of their responsibilities and identify a water safety champion that will be responsible for carrying out the requirement of the SOP and linking with Local Water Safety Group. The Local Water Safety Group will be responsible for maintaining a list of water safety champions and receiving the completed weekly flushing logs.</p> <p>Review of Terms of Reference for Local Water Safety Group to be carried out to align with reporting.</p>	26/01/2024	<p>Director of Nursing Infection Prevention and Decontamination</p> <p>Head of Operational Estates</p>
<p>2.2 Re-issue the SOP at Strategic Infection Prevention Group and highlight the importance of document and request that all wards and departments are reminded of their responsibilities and identify a water safety champion that will be responsible for carrying out the requirement of the SOP and linking with Local Water Safety Group. The Local Water Safety Group will be responsible for maintaining a list of water safety champions and receiving the completed weekly flushing logs.</p> <p>Review of Terms of Reference for Local Water Safety Group to be carried out to align with reporting.</p>	26/01/2024	<p>Director of Nursing Infection Prevention and Decontamination</p> <p>Head of Operational Estates</p>
<p>2.3 Instruction sent out by e-mail from Head of Operational Estates on 22<sup>nd</sup> December 2023 to ensure that a signature is applied to each line and not a single signature covering multiple lines on the flushing register. This action will be monitored at the Water Safety Group.</p>	23/12/2023	Head of Operational Estates

Matter Arising 3: Training and competence (Operation)		Impact	
<p>The Health Board is not meeting the requirements of Welsh Health Technical Memorandum 04-01 – Safe Water in Healthcare Premises Part B regarding training and competence assessments.</p> <p>Whilst training and competencies for Responsible Person(s) – Water and craftsmen working with water are mandated and monitored, there is no formal training provision or requirements (e.g. Water Hygiene / Legionella awareness etc), or competence assessments, for other staff groups that have direct duties and responsibilities impacting water safety (e.g. ward and department managers, facilities staff etc).</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• Failure to meet WHTM 04-01 requirements.</li> <li>• Lack of understanding / awareness amongst staff.</li> </ul>	
Recommendations		Priority	
3.1	<p>Management to ensure all staff members that have been allocated tasks and responsibilities impacting water safety (including outlet flushing, wash-hand basin / tap cleaning, maintenance, strategy development etc) have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting.</p>	<p><b>High</b></p>	
Agreed Management Action		Target Date	Responsible Officer
3.1	<p>Operational Estates staff have received the appropriate training to be able to carry out their duties / responsibilities safely.</p> <p>Design a training package (Power Point Presentation and Questionnaire to evidence learning) for Non-Estates staff and get it approved at Strategic Infection Prevention Group.</p> <p>Training package to be presented to all ward / departmental manager and facility management, the attendance at the training event will be monitored by reporting and escalating to the Water Safety Group / Strategic Infection Prevention Group.</p>	<p>03/01/2024</p> <p>22/02/2024</p> <p>31/05/2024</p>	<p>Head of Operational Estates</p> <p>Director of Nursing Infection Prevention and Decontamination</p> <p>Head of Operational Estates</p> <p>Head of Operational Estates</p>

Matter Arising 4: Risk management (Operation)		Impact
<p>We reviewed the risk management arrangements in place for water safety and found the following limitations:</p> <ul style="list-style-type: none"> <li>It is not clear whether the completed risk assessments adequately assess risks from Pseudomonas – the risk assessment narrative focuses predominantly on Legionella, though management believe the scope of the assessments are wider and includes Pseudomonas (e.g. policy, WSG, ventilation etc are included in the assessments).</li> <li>There is no formal process in place to ensure risk assessments are reviewed in compliance with the timescales stated in the Water Safety Plan.</li> <li>The Heath Board does not have an overarching Business Continuity Plan for site-wide loss of water supply and does not receive assurance from water providers regarding the quality and testing of their contingency arrangements / Emergency Response Action Plans.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Failure to assess the risk of Pseudomonas.</li> <li>Failure to comply with policy requirements.</li> <li>Lack of effective Business Continuity Plans.</li> </ul>
Recommendations		Priority
4.1	Management to confirm that risk assessments adequately assess risks from Pseudomonas.	<b>Medium</b>
4.2	Management to review risk assessments per the Water Safety Plan requirements to ensure continued relevance.	<b>Medium</b>
4.3	Management review Business Continuity Arrangements for loss of mains water and / or request assurance from water providers that their contingency plans / Emergency Response Action Plans are routinely tested.	<b>High</b>
Agreed Management Action	Target Date	Responsible Officer
4.1	The Risk Assessments provided by Safe Care are titled – HTM 04-01 Legionella Risk Assessment.’ The introduction section of the Risk Assessments does state that the assessment considers the requirements of the Health Technical Memorandum HTM	01/04/2024 Head of Operational Estates

	<p>04-01: The control of Legionella, hygiene, "safe" hot water, cold water, and drinking water systems Part A and B and HTM 04-01 Addendum (Pseudomonas).</p> <p>There is a requirement within Augmented Care areas that pseudomonas water testing is carried out on a frequency of 6 months and Operational Estates are compliant with this requirement and results are presented at the Water Safety Group Meetings.</p> <p>Operational Estates are in the process of re-tendering the Water Safety Contract and as part of the specification have requested that future Risk Assessment are titled 'Water Safety Risk Assessment and reference to current water testing regime within Augmented care areas which are currently undertaken.</p> <p>Operational Estates to review the Water Safety Plan and update to ensure that it's clear in the responsibility for augmented care area and notes the current testing regime that are in place for Pseudomonas within the plan.</p>		
4.2	<p>Risk Assessment monitoring spreadsheet has been developed and are being implemented within Operational Estates. The spreadsheet will have details of future review dates of assessments.</p> <p>The monitoring spreadsheet will be presented at future Water Safety Groups to ensure oversight and governance.</p>	01/03/2024	Head of Operational Estates
4.3	<p>There is a Business Continuity Plan in place for how Operational Estates manage the loss of Water within Hospital sites, but the Health Board does not have a Business Continuity for how operationally the sites will manage loss of water (Hand Hygiene, Provision of Drinking water etc.).</p> <p>Operational Estates have within the Water Safety Policy an annex that identifies where Local Water Authorities can connect water tankers to the existing infrastructure in the event of a prolonged water outage within the 3 acute sites.</p>	<p>01/05/2024</p> <p>01/04/2024</p>	<p>Emergency Preparedness Resilience and Response Leads</p> <p>Head of Operational Estates</p>


---

<p>Operational Estates are in discussions with both Welsh Water (Ysbyty Gwynedd and Ysbyty Glan Clwyd) and Hafan Dyfrdwy (Wrexham Maelor Hospital) to request their Business Continuity Plan in the event of mains water failure within an acute hospital site.</p>		
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--

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

### Audit Assurance Ratings

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

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

### Prioritisation of Recommendations

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

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

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



GIG  
CYMRU  
NHS  
WALES

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

NHS Wales Shared Services Partnership  
4-5 Charnwood Court  
Heol Billingsley  
Parc Nantgarw  
Cardiff  
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



<b>Teitl adroddiad:</b> <i>Report title:</i>	Update on Internal and External Audit Recommendations (Tracker Tool)			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	15 <sup>th</sup> March 2024			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The purpose of this report is to provide the Audit Committee with an update regarding the Health Board's position in the implementation of Internal Audit and External Audit recommendations.			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked;</p> <ul style="list-style-type: none"> <li>to note the current position (February 2024) of overdue audit recommendations</li> <li>take assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations</li> <li>to consider proposed recommendations for closure.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Acting Board Secretary, Phil Meakin			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i> <input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i> <input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i> <input checked="" type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<p>Even though a considerable amount of work has taken place since the last Audit Committee on 12th January 2024 to ensure that all open recommendations were correctly assigned and updated with realistic implementation dates, a number of overdue recommendations remain open, with many of these being of 'high' priority, with some updates for this Audit Committee remaining outstanding or incomplete. The Internal and External Audit recommendations have also been discussed at the Formal Executive</p>				

Team meetings. As usual guidance and support is provided by the Office of the Board Secretary (OBS) to all recommendation action owners and the final approvers.	
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>	Not applicable, other than those relating to individual audit reviews/recommendations.
<b>Link to Strategic Objective(s):</b>	
<b>Goblygiadau rheoleiddio a lleol:</b>	Compliance with Internal and External Audit requirements.
<b>Regulatory and legal implications:</b>	
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
<b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b>	
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
<b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>	
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>	Not applicable, other than those relating to individual audit reviews/recommendations.
<b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>	
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>	Not applicable, other than those relating to individual audit reviews/recommendations.
<b>Financial implications as a result of implementing the recommendations</b>	
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>	Not applicable, other than those relating to individual audit reviews/recommendations.
<b>Workforce implications as a result of implementing the recommendations</b>	
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>	Feedback and discussion of the Formal Executive Team meeting on 17 <sup>th</sup> January 2024 is detailed below in the body of the report. The Chair of Audit Committee is yet to meet with the Executive Director of Operations to gain further assurance on those recommendations where no update has been received.
<b>Feedback, response, and follow up summary following consultation</b>	
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	Not applicable, other than those relating to individual audit reviews/recommendations.
<b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>	
<b>Reason for submission of report to confidential board (where relevant)</b>	
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b>	

**Next Steps:****Implementation of recommendations**

The Tracker is normally presented to each quarterly meeting of the Audit Committee, but is presented bi-monthly due to partial assurance. The OBS continues to provide support and advice for recommendation owners and final approvers/Executive leads.

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

- Appendix 1 – Audit Tracker – All Open External Audit Recommendations
- Appendix 2 – Audit Tracker – All Open Internal Audit Recommendations
- Appendix 3 – Audit Tracker – All Recommendations Proposed for Closure by Executives
- Appendix 4 – Audit Tracker – All Recommendations - Outstanding or Incomplete Updates
-

## 1. INTRODUCTION AND BACKGROUND

This report provides an update on all Internal and External Audit Recommendations that remained open following the last Audit Committee meeting on 12<sup>th</sup> January 2024, as well as a number of recommendations proposed for closure following the Committee's consideration. Also included is a list of recommendations where the updates are outstanding or incomplete.

The Audit Committee agreed to close 49 recommendations pending review and approval by Internal Audit. All those recommendations have been excluded from the Audit Tracker in this iteration of the report and have been submitted to Internal Audit, pending approval for closure.

Further to this, the Internal and External Audit Recommendations were discussed at the Formal Executive Team meeting on 17<sup>th</sup> January 2024, where the following was agreed:

- Step 1 Executive leads to re-scrutinise the relevance of some of the older recommendations reviewing what can be closed ensuring rationale and decisions are documented and presented to Audit Committee and Internal Audit. (Completed)
- Step 2 Escalate outstanding actions for discussion. (Completed)
- Step 3 Repeat bi-monthly ensuring Internal Audit are provided with assurance
- Step 4 Meeting between Audit Committee Chair to discuss Executive Director of Operations outstanding recommendations. Outstanding.
- Step 5 Demonstrate assurance on robust processes and improved position to Audit Committee on 15<sup>th</sup> March 2024. (5 actions remain outstanding for updates and has been escalated to the Executive Team). This is an improved position from the last report, where there was a total of 142 open audit recommendations, compared to this iteration, where there are a total of 114.

## 2. STATUS UPDATE

### 2.1 External Audit recommendations

There are 3 external audit recommendations, all of which are 'high' priority – one is recommended for closure, and the other two remain open (started).

ID	Recommendation Title	Assurance rating	Audit recs - Priority			Audit recs - Implemented			Audit recs - Overdue agreed timescale			All Audit Recs implemented
			H	M	L	H	M	L	H	M	L	
210	CHC Service Delivery	Reasonable	1			0			1			No
230	R1b	N/A	1			0			1			No
244	R1	N/A	1			1			1			Yes

Please see Appendix 1, Audit Tracker - Open external audit recommendations.

One external audit recommendation proposed for closure is included within Appendix 3.

### 2.2 Internal Audit Recommendations

There are 111 open internal audit recommendations in total, a reduction of 50 from the last submission.

All open internal audit recommendations are included in Appendix 2.

The full list of recommendations proposed for closure by Executives, including the one external audit recommendation is included in Appendix 3.

#### 2.2.1 2020 Audit Recommendations

In 2020, there are 3 internal audit recommendations on the tracker, all 'high' priority, with one being proposed for closure, and the other two remaining open (started).

ID	Recommendation Title	Assurance rating	Audit recs - Priority			Audit recs - Implemented			Audit recs - Overdue agreed timescale			All Audit Recs implemented
			H	M	L	H	M	L	H	M	L	
57	Quality Improvement Strategy	Limited	1			1			1			Yes
226-227	Continuing Healthcare Arrangements	N/A	2			0			2			No

#### 2.2.2 2021 Audit Recommendations

In 2021, there were 4 internal audit recommendations:

- 1 'high' priority remaining open
- 3 'medium' priority, all 3 remain open
- No 'low' priority recommendations.

ID	Recommendation Title	Assurance rating	Audit recs - Priority			Audit recs - Implemented			Audit recs - Overdue agreed timescale			All Audit Recs implemented
			H	M	L	H	M	L	H	M	L	
73	Performance measure reporting to the Board – Accuracy of information	Reasonable		1			0			1		No
123	Procurement and Tendering	Reasonable		1			0			1		No
146	Women's Services Division – Sustainability of services	Reasonable	1	1		0	0		1	1		No

## 2.2.3 2022 Audit Recommendations

In 2022, there were 46 internal audit recommendations:

- 37 'high' priority, 21 of which is proposed for closure, 16 remain open (started), none pending.
- 6 'medium' priority, 3 of which are proposed for closure and 3 remain open (started).
- No 'low' priority recommendations.

ID	Recommendation Title	Assurance rating	Audit recs - Priority			Audit recs - Implemented			Audit recs - Overdue agreed timescale			All Audit Recs implemented
			H	M	L	H	M	L	H	M	L	
114-118	Standards of Business Conduct: Declarations	Limited	3	2		3	2		3	2		Yes
148-149	Employment of Medical Locum Doctors	Reasonable	1	1		0	0		1	1		No
150-152	Roster management	Limited	2	1		0	0		2	1		No
154-155	Establishment control – Leaver management	Limited	1	1		0	0		1	1		No
158-161	On-Call arrangements	Limited	4			0			4			No
169	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	Limited	1			1			1			Yes
172-173 and 175	Effective Governance: YWM	Limited	3			2			3			No
178	Effective Governance: YG	Limited	1			1			1			Yes
183-186	Board and committee reporting	Limited	4			3			4			No
187-187 and 190	Chairs action	Reasonable	1	2		1	1		1	2		No
194-196 and 198	Charitable Funds	Limited	2	2		0	0		2	2		No
235, 238, 240, 241	Review of Eye Care Services	N/A	4			2			4			No
308-316	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	Limited	9			8			9			No

## 2.2.4 2023 Audit Recommendations

In 2023, there are 59 internal audit recommendations on the tracker:

- 47 'high' priority, 17 of which are proposed for closure, 5 pending (not yet due) and 25 open (started).
- 12 'medium' priority recommendations, 7 proposed for closure, and 5 open (started).

ID	Recommendation Title	Assurance rating	Audit recs - Priority			Audit recs - Implemented			Audit recs - Overdue agreed timescale			All Audit Recs implemented
			H	M	L	H	M	L	H	M	L	
203	Delivery of Health Board Savings	Limited	1			0			1			No
206-207	MH&LD	Reasonable	1	1		0	0		1	1		No
215-218	USC: Urgent Primary Care Centres - Business case outcomes achieved	Limited	2	2		1	1		2	2		No
220	Public Health - Smoke free sites	Reasonable		1			0			1		No
247	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	Limited	1			0			1			No
252,, 254	Risk Management and Board Assurance Framework	Limited	2			1			2			No
256-257	Planned Care Recovery and Transformation Group	Limited	2			1			2			No
258-260	Data analysis – Triangulation of data	Limited	3			2			3			No
261-265	Contracted Patient Services: Quality and Safety Arrangements	Limited	5			0			4			No
267-268, 270	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Limited	3			1			1			No
273	Hergest Unit Notice of Contravention (NoC) Action Plan	Limited	1			1			1			Yes
276	Accounts Receivable	Reasonable		1			0			1		No
284-289	GP Out of Hours	Limited	2	4		0	3		2	4		No
290-292, 294-296, 298-301, 303-304, 306-307	Falls Management	Limited	11	3		5	3		9	3		No
317-319	Decarbonisation	Limited	3			1			0			No
320-328	Lessons Learnt	Limited	9			2			0			No
329	Adult and Older Persons Mental Health Unit	Reasonable	1			0			1			No

## 3 OPEN INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS BY EXECUTIVE LEAD

Below is a table showing the open internal and external audit recommendations, by Executive Lead.

Executive	Total open recommendations
Executive Director of Nursing and Midwifery	17
Interim Executive Director of Operatons	16
Interim Executive Director of Finance	11
Deputy Director of People	8
Executive Director of Transformation and Strategic Planning	5
Acting Board Secretary	3
Interim Director of MHLD	2
Health Board Lead for MHLD and Welsh Language	2
Executive Medical Director	0
Chief Digital and Information Officer	0
<b>Total open recommendations - internal and external</b>	<b>64</b>

#### 4 **OUTSTANDING OR INCOMPLETE UPDATES**

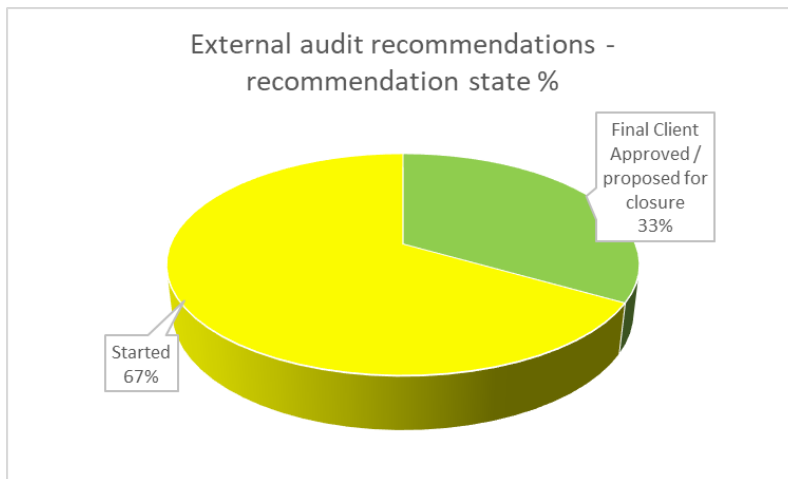
A total of 3 recommendations updates remain outstanding or are incomplete – this is where evidence to support closure has not been provided, or a revised implementation date not provided following the OBS quality assurance process.

The list of recommendations awaiting/outstanding updates is included in Appendix 4. This is an improved position from the last iteration, where 26 recommendations were outstanding at that time.

#### 5 **ANALYSIS**

##### 5.1 **External Audit Recommendations:**

The overall number of external audit recommendations from 2020 to 2023 is 3, and 2 remain open as below.

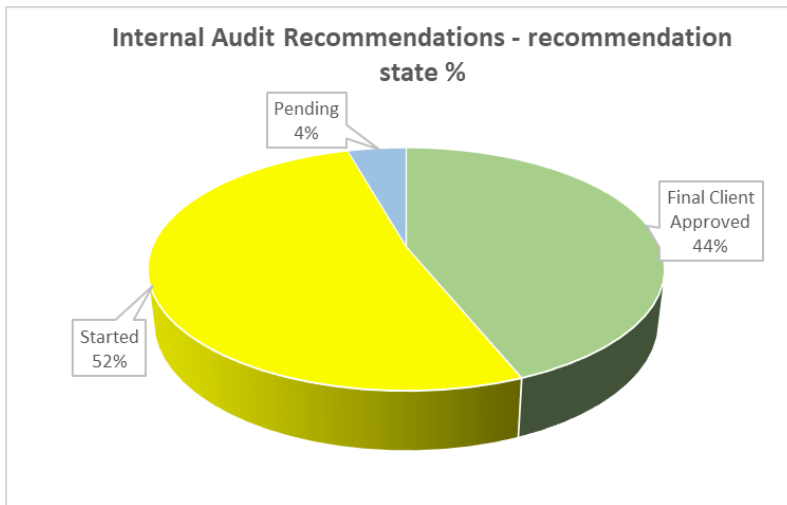


The two open external audit recommendations are high priority, and both are overdue their original implementation date.

This is an improved position since the last iteration, where there were 9 open external audit recommendations, with 6 of those put forward for closure.

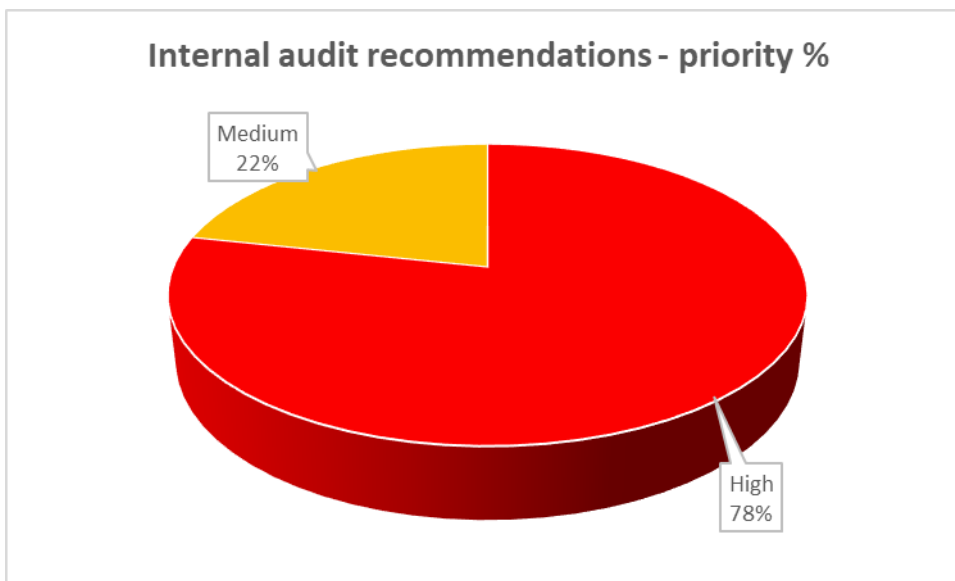
## 5.2 Internal Audit Recommendations:

Below is the percentage of each internal recommendation, by recommendation state:



From the update provided to the last Audit Committee, there is an improvement of 6.7% in the total number of proposed for closure, and 3% in total number pending, with no change in the percentage of started recommendations.

Below is the percentage of each recommendation, by priority.



The overall number of internal Audit recommendations from 2020 to 2023 is 111, which includes.

From the update provided to the last Audit Committee, there is a deterioration of 2% in the total number of open high priority recommendations, but an improvement of 2% in the number of open medium priority recommendations.

	<b>Total</b>	<b>%</b>
Total number proposed for closure by Executive	49	44%
Total number open (started)	57	51%
Total number pending (not yet due)	5	5%

Of the 111 open internal audit recommendations;

	<b>Total</b>	<b>%</b>
High priority	87	78%
Medium priority	24	22%
Low priority	0	0%
Total overdue	95	86%

## 6 **UPDATE ON DEVELOPMENTS FOLLOWING PREVIOUS AUDIT COMMITTEE**

Since the last Audit Committee in November 2023, work has been undertaken to further develop and improve the tracker, with the continued additional support by a senior members of OBS team to improve the structure and flow of the tracker, and provide challenge around the quality of updates.

Following the loss of the tracking software, work is continuing to develop a Sharepoint site and PowerAutomate process to ensure robustness, efficiency and ease of access. The completion of this work is in the final stage and the roll out is currently dependent upon the approval of the process of recommendations 'closed' recommendations. This is aimed to be rolled out in April ahead of the next Committee and will improve the robustness of the maintenance and logging of the tracker.

## 7 **CONCLUSIONS**

Out of the 114 recommendations on the tracker, 90 of these are 'high' priority and 24 'medium' priority. There are no open 'low' priority recommendations.

However, a total of 40 'high' priority recommendations and 9 'medium' priority are proposed for closure. In relation to 'high' priority recommendations, this is an improved position by 13 from the last Audit Committee update, but a reduction of 11 in the total number of 'medium' priority recommendations submitted for closure at the last Audit Committee.

From the 114 recommendation, a total of 50 'high' priority and 14 medium recommendations remain open, with 5 pending.

Only one of the proposed recommendations for closure is an external audit recommendation.

## 8 **RECOMMENDATION**

If the Audit Committee is in agreement, all recommendations proposed for closure by the Executives, including evidence to support closures, will be shared with Internal Audit for their review and final approval, reflecting the process undertaken following the last Audit Committee on 12<sup>th</sup> January 2024.

**APPENDIX 1 – AUDIT TRACKER – ALL OPEN EXTERNAL AUDIT RECOMMENDATIONS**

**APPENDIX 2 – AUDIT TRACKER – ALL OPEN INTERNAL AUDIT RECOMMENDATIONS**

**APPENDIX 3 – AUDIT TRACKER – ALL RECOMMENDATIONS PROPOSED FOR CLOSURE BY EXECUTIVES**

**APPENDIX 4 – AUDIT TRACKER – ALL RECOMMENDATIONS - OUTSTANDING OR INCOMPLETE UPDATES**

AUDIT COMMITTEE

AUDIT TRACKER - ALL OPEN EXTERNAL RECOMMENDATIONS

ID	Committee	Internal Audit (IA)/ Wales Audit Office (WAO)	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Update provided to 12/01/2024 Audit Committee	Update for 15/03/2024 Audit Committee	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions
210	PFIG	Wales Audit Office	Audit Wales CHC follow-up	2022	Reasonable	High	CHC Service Delivery	Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered.	The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development. Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical and Enabling Services and Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group.	There has been some progress against this action to ensure the Health Board is operating in line with the Framework. Key areas have been reviewed to ensure consistency across the 3 IHCs and Mental Health, and improved processes to provide greater assurance have been implemented e.g. Escalation Process and funding by exception. Further areas for focus have been identified and will be implemented and monitored as part of continued progress.	A number of task and finish groups have concluded on a number of areas to ensure that there is consistency across the 3 IHCs and MH&LD e.g. Placing in Care homes by exception, Disputes process, Training and education. Other workstreams around consistency of approach in regards to complex care, managing back log of reviews, fees queries and section 117 continue. Since the Audit, the executive lead has been confirmed and the work is progressing by identifying work programmes for improvement as opposed to a whole system approach. National work has also commenced in relation to CHC efficiencies, roles, competencies and structures. It is recommended this action target date be extended, continue to embed the improvement programmes and await the recommendations from the national team.	Jane Trowman, Head of Strategy and Health Planning	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2023	30/06/2024	2
230	PFIG	Wales Audit Office	Structured Assessment (Phase 2) 2021	2021	N/A	High	R1b	Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.	The business case process is being updated and simplified and will include an assessment of: the relative efficiency of the specific service; what action has been considered to improve that efficiency ahead of the business case.	The independent planning review is due to conclude in the last quarter of the calendar year. Part of the governance and planning reviews outcome will be the requirement to review the business case process from an IHC local level to that of an BCU wide business case level with scrutiny panels and committees defined.	- Updates provided to QEDG on a quarterly basis.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director Transformation And Strategic Planning	Started	31/01/2022	31/05/2024	6

**AUDIT COMMITTEE**  
**AUDIT TRACKER - ALL OPEN RECOMMENDATIONS - INTERNAL AND EXTERNAL**

ID	Committee	Internal Audit (IA)/ Wales Audit Office (WAO)	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Update provided to 12/01/2024 Audit Committee	Update for 15/03/2024 Audit Committee	Action Owner	Final Approver	Recommendation State	Original Implementation date	Revised Implementation date	Number of Revisions	For closure consideration at 15/03/2024 Audit Committee?
73	PFIG	Internal Audit	Performance measure reporting to the Board – Accuracy of information	2021	Reasonable	Medium	Standard Operating Procedure	Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Detailed sign-off rules via the Planned Care Board and Planned Care Transformation Group. The basis of information controls and procedures are formally documented.	The RTT 26 Week Pathways Standard Operating Procedure is out for consultation and awaiting response from stakeholders. Previous feedback comments are being fed into the document and once all responses are reviewed the Standing Operating Procedure will follow the official sign-off rules via the Planned Care Board and Planned Care Transformation Group. The basis of information controls and procedures are formally documented.	Update required	The RTT 26 week SOP has been created and ratified, the education and training of this SOP has been conducted August 2021. However, since the creation of the document West have migrated onto WPAS from IPM and an Access Policy has been created that will supersede this document. The Access Policy has concluded final consultation and is being ratified.	Andrew Oxbey, OPD Programme Support Manager	Adele Gittoes, Interim Executive Director of Operations	Started	02/08/2021	30/04/2024	5	No
123	PFIG	Internal Audit	Procurement and Tendering	2021	Reasonable	Medium	eWaiver system	Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met.	3.1 We will investigate the possibility of updating the eWaiver system (as part of the 365 redesign) to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended.	Go live has been put back until November to allow time to incorporate some key governance updates in the waiver process. The eWaiver system has been reviewed and updated with the intention of using 365 functionality. Additional enhancements have been made in line with SF1 and SORD (approved by Board 30/11/2023). Soft launch scheduled imminently (December 2023).	The Finance Department have been re-developing the waiver system and following a period of user testing and a soft launch in December 2023, the system went live in February 24. Key areas of improvement are system compliance with delegated limits contained within the Scheme of Reservation and Delegation (SORD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary, and improved reporting.	Denise Roberts, Head of Capital, Tax and Business Support	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2022	31/12/2023	9	No
146	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	Medium	Escalation of issues	Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.	SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and present to the Health Board's, Chief Executive Officer on 22/10/2021. Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board's Chief Executive Officer, for the attention of Chester CCG's Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences at BCUHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation Trust. Update on actions taken within the Women's Division, in respect of the ongoing quality assurance concerns in the Maternity Service provided at the Countess of Chester, presented at the Women's Executive Accountability meeting on 5/11/21 and at Corporate PSQ on 9/11/21. Quality and Safety Audits and Assurances required during a pandemic and when formal contract management reporting resumes, to be formally and agreed with the Countess of Chester Provider Team on 24/11/21.	Update required	A formal request via the BCUHB Contracting Team has been submitted to request an update from the Countess in relation to: CQC follow up finding and Report in relation to Maternity - It has been confirmed that the report is not available as they are still within the inspection phase. - Clinical Outcome measures and KPI Performance now reported Quarterly to the HB via the Contracting Team. - CQC - Maternity Improvement Plan and Assurance Outstanding (9-2-24). - Updates provided to QEDG on a quarterly basis.	Fiona Graud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	31/03/2024	8	No
147	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	High	Finance and Contracting Arrangements	The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: Contracting to share monthly data with Women's to enable periodic review and reconciliation. The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.	NHSE Guidance issued in response to the Covid 19 (March 2020 extended for 2021/22) pandemic which Welsh Government has adopted, stood down the requirement for a formal signed contract and contract management and reporting requirement, these will however be re-established once that guidance changes. Despite the guidance BCUHB Contracting Team has continued to meet with providers and data has been continued to be received during the pandemic. COCH implemented a new patient system in July 2021, there have been difficulties with the implementation which has resulted in BCUHB not receiving regular reports. This has been raised at meetings with COCH, formal correspondence has now been sent by the Contracting Team and a formal action plan requested for resolution. Activity data will continue to be validated for responsible commissioner and undertakes a series of validation checks regarding tariff and coding. Contracting to share monthly data with Women's to enable periodic review and reconciliation where queries arise these will be raised through the contract process once re-established formally by NHS England and Welsh Government and if required Clinical Audits will be pursued. Contracting have built links to Cheshire CCG as the lead commissioner for the main acute services at Countess of Chester and any significant assurance reports are now shared with the Health Board. BCUHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUHB whilst working outside of normal contracting arrangements, during a pandemic.	Update required	- Clinical Outcome measures and KPI Performance now reported Quarterly to the HB via the Contracting Team. - CQC - Maternity Improvement Plan and Assurance Outstanding (9-2-24). - Updates provided to QEDG on a quarterly basis	Fiona Graud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	31/03/2024	2	No
148	People Committee	Internal Audit	Employment of Medical Locum Doctors	2022	Reasonable	Medium	Justification Notes	All requests for recruitment of locum medical staff should be completed to a good level and include all necessary information and justification notes, which will facilitate an effective audit trail.	Clear guidance on minimum information required to be developed in liaison with Finance and Associate Medical Director Professional Standards (Office of the Medical Director 'OMD'). Quarterly compliance audit will be undertaken by WOD/Fin/OMD and included in Contract management information	Due to the changing financial position of the Health Board, the response to this action has been amended as the prior solution was not suitable. In October 2023, a new Rate Approvals group was put in place where services are required to submit detailed justification for high cost locum bookings. Linked to this, a new Temporary Medical Workforce Policy has been developed. The new policy is planned to be ratified in Q4 2023/24.	M&D Medical Locum Staff governance infrastructure implemented and is operating effectively. The new Temporary Medical Workforce Policy has been written, developed and is currently undergoing consultation and engagement activities via the various HB committee structures and is still on track to be fully ratified in Q4 2023/24.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	29/02/2024	6	No
149	People Committee	Internal Audit	Employment of Medical Locum Doctors	2022	Reasonable	High	New Recommendation	The Health Board ensures there is a robust process to monitor the performance of the contract and this should be reflected in the Health Board Standard Operating Procedure/policy.	Tripartite Contract Management meetings to be arranged on a monthly basis. Tripartite Senior Contract Management meetings to be held quarterly.	The new BI dashboard is under development and due to be launched by January 2024.	This has been delayed due to staff shortages and sickness across the team and the ability to get the dashboard signed off by senior managers in workforce. The industrial action by junior doctors has also delayed getting final sign off from senior medical leads. Final sign off and launch will be completed by end of February 24.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	29/02/2024	4	No
150	People Committee	Internal Audit	Roster management	2022	Limited	Medium	Policies and Procedures	Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. Draft SOP needs to be approved and activated.	Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.	The policy renewal took place but ongoing monitoring has shown that further work, led by the nurse optimisation team, is needed in relation to compliance with managing breaks. This is linked to the programme of work to move all nurses onto the e-Roster system to help applying a consistent approach to unpaid breaks across the HSC.	Further work is ongoing with the Nursing Teams to ensure full compliance is in place to support compliance with the SOP. Work is also underway to hand over the compliance monitoring to the HIC Nursing and People Service teams as part of embedding the oversight and ownership of the process into business as usual practice.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/07/2022	29/02/2024	2	No
151	People Committee	Internal Audit	Roster management	2022	Limited	High	Submission of timesheets by agencies	Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements.	Formal letter to be issued to all agencies from Executive Director of Workforce and Organisational Development. Communication to be sent to all Heads of Nursing, Matrons and Ward Managers to emphasise requirement to lock down and record variations to working hours. Training sessions to be held again with Heads of Nursing, Matrons and Ward Managers to ensure understanding of requirements	It has been identified that further work with nursing is needed to improve compliance with the policy and locking of shifts in a timely manner.	Further training has been provided on roster management to incorporate lock down of shifts and completion of timesheets in a timely manner across identified nursing teams. KPIs are being monitored and will be reported as part of ongoing compliance metrics to ensure shifts are locked down within the required timescales.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	29/02/2024	2	No

152	People Committee	Internal Audit	Roster management	2022	Limited	High	Implementation of 1 hour breaks	The Temporary Staffing Team to regularly review 12 hour shifts on the system (prior to submission to payroll) and amend the break times as per the procedures. 3.2 Agencies are formally reminded of the requirement to input breaks according to the timesheets submitted, and reminded of the declaration included on the system where they are confirming the details entered are correct. 3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets/exception sheets before they are locked for payment. 3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments. 3.5 The Temporary Staffing team should regularly check a sample of shifts on the system against paper timesheets retained by agencies.	(as per 1.2) Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care. Revised SOP approved by People and Culture Executive Delivery Group and implemented	The actions relating to this response were completed, however, it has been identified that further improvements are needed to ensure roster users are following the new SOP.	The SOP has been further embedded and a rolling audit cycle is now being put in place to ensure all areas remain fully compliant.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/08/2022	29/02/2024	2	No
154	People Committee	Internal Audit	Establishment control – Leaver management	2022	Limited	High	Operational management compliance	Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badges; and Network access is revoked.	The Workforce Performance and Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation. The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager; however, ESR will serve as the prompt and workforce teams can monitor and escalate if compliance is not adhered to. The specific actions will be: 1. To advise the NWSSP Team, wider stakeholders i.e., Finance, HR that with effect from the 1 February 2022 the team will be requesting all future agenda for change staff terminations to be completed via ESR Self Service. 2. Issue a BCU wide communication to advise that with effect from the 1 February 2022 all agenda for change staff terminations must be completed via the ESR Self Service system. 3. Initiate a mass update from IBM to add against each staff member a minimum property list of ID Badge and IT equipment/Network access credentials. 4. ESR function actioned so that a notification is sent of individual staff terminations to specified colleagues/groups. This will be piloted with IT and Security to ensure the notifications are received with the relevant information i.e.: employee leaving date with a view to stop the monthly leavers report issued to IT as terminations will be notified in real-time.	No 4. - There remain technical issues to be resolved with the existing changes forms and self service function which has impacted the completion of this action. Whilst the ESR Self Service system sends the notifications to IT colleagues, it does not provide the details required. IT colleagues need to understand if the leaver requires their NADDEX account to be terminated and leaving BCU is not always an indicator to terminate the NADDEX as they may be moving to another NHS organisation in Wales or retiring and returning to BCU, the recent Pension changes will help address the retire and return staff members. A new all Wales changes form (Staff Movement Advice) is due for release in 2024 and will be expected to resolve this action.	This is still an outstanding issue and sits outside of BCUs direct control as it is a NWSSP initiative. The current expected delivery date we have been advised of is 31/04/24. As far as the team are aware this is still on track and regular updates are requested from the Shared Services Team responsible for implementing this across Wales.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/01/2022	31/04/2024	3	No
155	People Committee	Internal Audit	Establishment control – Leaver management	2022	Limited	Medium	Leaver data provided to areas/departments	Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas/departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce and OD.	There are four interventions to assist with supporting the wider leaver management reporting process: 1. The monthly production of the ESR Leavers Report compared to the ESR Change Event Log by Division. This will highlight the number of leavers terminated in ESR after the leaving date, this will be grouped by month for high level numbers. 2. The monthly review of Establishment Control requests which highlight the EC request relating to a team member being replaced. The check to be completed will be comparing the team member noted on the EC request with the ESR Leavers Report and follow up action with the EC requestor regarding why the team member hasn't moved departments or been terminated. 3. Both interventions above will ensure that non-compliance reporting is more targeted. The enhanced reports will be included in the monthly exception reports and shared with Heads of HR and with relevant Senior Leadership Teams. Each quarter the report will be aggregated and will include details of the supervisors who are repeat offenders. 4. Where there is a lack of compliance training and support will be put in place in conjunction with IT and IG to ensure managers are fully equipped to carry out the actions required.	1 - Complete 2 - Complete 3 - For re-review to ensure the data is being reviewed from within the Teams Channel and/or included in Workforce BI Dashboard 4 - For re-review.	3 - The details being shared with managers has been reviewed and is amended to provide more detailed information. 4 - This is under an ongoing discussion with IT and IG currently and a solution should be in place by agreed revised implementation date.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/01/2022	31/03/2024	1	No
158	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Review of on-call arrangements	1.1a The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. 1.1b Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. 1.1c Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1a The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead. 1.1b Proposals will be presented to the Executive Team, for approval.	Update required	Review re-commenced in light of WOD elements raised formally. T&F group to be convened with Silvers/BOG to develop governance/policy and training with a clear plan by April 2024 for implementation in line with all Wales on call process.	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/10/2022	01/06/2024	3	No
159	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Rota guidance/sustainability	The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it.	2.1 On-call document, covering the recommendations above will be issued to all staff.	Update required	A request has gone through the all Wales EPRR teams for copies of any local on-call policies or check the appetite for an all Wales policy that supports all levels of staff, which will manage governance, payment, rest periods. Responses have been requested by month end in light of the ongoing delays.	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	01/07/2022	01/06/2024	1	No
160	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Compensatory rest and payment	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	3.1a All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce and OD, and Deputy CEO.	Update required	National support has been requested in light of duration for internal review / updates request has gone through EPRR forum across Wales.	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	11/07/2022	01/06/2024	1	No
161	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Training	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey. 4.1b Manual to be developed with key information, and details for those on call. 4.1c All staff to receive training with a programme and timescale set for refresher training every two years. 4.1d Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	Update required	National support has been requested in light of duration for internal review / updates request has gone through EPRR forum across Wales.	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/12/2022	01/06/2024	1	No

173	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Clinical Audit	3.1a The list of Tier 3 audits should be shared with the East Clinical Effectiveness Group to ensure audits are focused on the risks within the site and that there is no duplication of audits/efforts across the site. This would also provide opportunities for work across more than one division/locality. 3.1b Results and lessons from Tier 3 audits should be documented and shared across the Health Board. Noting that divisions/facilities are responsible for Tier 3 audits, we would suggest the learning/feedback is provided to the East Clinical Effectiveness Group and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board.	The East Clinical Effectiveness Group is established in the new governance plan and includes both the YWM and Community Services Medical Directors, so is already happening. The Director of Nursing for East chairs this and the T3 audits are shared in this forum, as are the results and recommendations. The imminent commencement of a newly appointed EHC Medical Director will enable, as part of the wider team, a robust, structured approach to developing and delivering the action plans.	Update required	The East HIC Clinical Effectiveness Group (ECEG) is now established and chaired by the secondary Care Medical Director. It covers the full breadth of the EHC. There is input from the clinical audit team. AMAA is established as the tracking system for the Tier 1, national and corporate audits. It is not yet being used for the Tier 3 audits but we will work on this in 2024.	Emma Jane Hosking, Hospital Site Medical Director/ Consultant Anaesthetist	Adele Gittoes, Interim Executive Director of Operations	Started	23/11/2022	28/02/2025	2	No
184	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Submitted papers meet the Board / Committee requirements.	2.1 Management to ensure that papers and reports submitted to the BCUH Board, Committees, or Advisory Groups are of the expected standard, meet the requirements of the Board / Committee and have been reviewed and quality checked prior to being submitted. Submissions to comply with Board / Committee Paper Assurance and Publication SOP. 2.2 Health Board to consider undertaking a root cause analysis of Board and Committee paper and report quality to determine whether there are underlying factors impacting the frequency of issues raised and determine appropriate solutions.	2.1 We will put in place three line of defence processes in assurance reporting, which will focus more on the requirements of the Board and its Committees, as well as the evidence required at an executive level to be produced. This will also be incorporated within the Board and Committee effectiveness review and incorporated within the overall action plan, which is aligned to the Board development programme. 2.2 Accepted, root cause analysis to be undertaken as a result of the Board and Committee effectiveness review.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. A SOP is now in place and will be monitored with regards to compliance and standards. The Office of the Board Secretary will develop a new report format and roll out training with regards to report writing. It is worth noting that the original action was completed, however the Acting Board Secretary wants to further improve report writing standards.	Further work will be done on this when new Director of Corporate Governance comes into post	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/03/2023	29/02/2024	1	No
190	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	Medium	Lessons learned	4.1 There should be a periodic review of Chair's actions to determine the reason for the action and to establish if any changes need to be made to current process/approval routes. 4.2 The Health Board should liaise with Board Secretaries/Office of Board Secretaries from HB3 and HB4, which may highlight areas where lessons can be learned to aid in reducing the number of actions.	4.1 The Board Secretary and Head of Corporate Affairs to review on a Yearly basis the Chair's Actions brought throughout the year. 4.2 Discuss at the national Board Secretaries forum what other organisations are doing and understand if there is the appetite for a once for all Wales approach to the Chair's Action Process.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Data set for March review in Office of the Board Secretary calendar.	There has been a dramatic reduction of Chairs Actions but the formal review of it will take place in March 2024	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/01/2023	29/02/2024	1	No
194	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Charitable Funds Committee	2.1 Review Membership of the Charitable Funds Committee in light of Executive changes, including the quorum required for meetings and update Terms of Reference to reflect any revisions. We suggest a minimum 2 Executives and 2 Independent Members, recognising the wider pool of IM and Executives who are Board of Trustee Members. 2.2 Review responsibilities and objectives of Committee and consider the regular information provided including more qualitative data on the operation of the Charity, updating the Terms of Reference to reflect any revisions. 2.3 Undertake a review of the effectiveness of the Charitable Funds Committee, in line with the requirements of the Terms of Reference (2.1) of the Committee, including requirements of the Charity Commission.	2.1 New Terms of Reference to be approved by the BCUHB Chairman, the Chair of the Charitable Funds Committee and the Executive Team and submitted for approval by the Charitable Funds Committee and ratified by the Trustee Board. 31/03/23 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to all Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate. 31/03/23 Interim Board Secretary: 2.3 Undertake an effectiveness review of the Committee via survey/interview of all Committee members and non-member regular attendees, and commit to a plan for reporting this and scheduling it in on an annual basis. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item.	The draft CFC ToR is being presented for approval at the CFC 01/24 for ratification at the Trustees AGM 01/24.	2.1 New Terms of Reference to be approved by 31/03/24 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate by 31/03/24 Interim Board Secretary COMPLETED. 2.3 Undertake an effectiveness review of the Committee in line with BCUHB process ONGOING. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item COMPLETED	Kirsty Thomson, Head of Fundraising - Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	31/01/2023	31/03/2024	2	No
195	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Strategy	The Charity Strategy should be presented to Board of Trustees for review and approval.	Charity Strategy to be submitted for approval to the December 2022 Charitable Funds Committee and presented for ratification at the January 2023 Trustees meeting.	The Charity Strategy was approved by the CFC on 03/10/23. The strategy will be ratified at the Trustees AGM 01/24.	The Charity strategy is due to be considered by the Executive Team on 28/02/24 and then submitted for approval by the Charitable Funds Committee on 15/03/24	Kirsty Thomson, Head of Fundraising - Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	31/01/2023	31/03/2024	2	No
196	PFIG	Internal Audit	Charitable Funds	2022	Limited	Medium	Policies and Procedures	4.1 Policies and procedures are reviewed to ensure any changes are reflected. Feedback from the Fund Advisor questionnaire should be incorporated when reviewing the procedures. 4.2 Training for Fund Advisors is reviewed and recommenced as soon as possible.	4.1 Financial Procedures to be reviewed and submitted to the Charitable Funds Committee in March 2023 for approval. Engagement and Communications Procedures to also be drawn up for approval by the Charitable Funds Committee in March 2023. 4.2 New Fund Advisor training package and communications plan to be in place and resourced by April 2023.	The draft Charity Procedures are being presented for approval at the CFC 01/24. New Fund Advisor and Service / Area Charitable Funding Advisory Groups information and training to be introduced from 03/24.	Revised Charity Procedures are being presented for approval at the CFC on 19/03/24. New Fund Advisor and Service / Area Charitable Funding Advisory Groups information and training to be introduced from 12/24.	Kirsty Thomson, Head of Fundraising - Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	30/04/2023	31/07/2024	2	No
198	PFIG	Internal Audit	Charitable Funds	2022	Limited	Medium	Expenditure	A process should be put in place to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity.	A dedicated Grants Manager will be in post by March to ensure a more robust process can be put in place to track funding requests and monitor, evaluate and report funding outcomes and outputs for all charitable activity	The Grants and Data Manager responsible for implementing the actions relating to this recommendation is currently off work. Due to the subsequent reduced capacity in the Charitable Funds and Charitable Partnerships Support team, the actions have not been completed in the anticipated timescale. The revised timeline to improve the process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is as follows: Complete: introduce new application summary template to highlight clear outcomes and outputs for all funding requests, which can be monitored and evaluated; Q3 2023/24 introduce new online application system for all funding requests and update guidance for all charitable funding applicants; Q4 2023/24 introduce a more sophisticated online system to monitor and record updates and evaluations from applicants to be included in Charitable Funds Committee reports and charity communications (subject to the approval of new systems Enhuse charity marketing platform, Donorly CRM, and ProGrant / other grant management system by IT & IG). The process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is included for noting in the January Charitable Funds Committee (CFC) papers and Grant Management is now a standing item within the Team Update paper submitted to the quarterly CFC meetings.	The Grants and Data Manager responsible for implementing the actions relating to this recommendation has resigned from his role, and the duties undertaken by this staff member have been reallocated to team members on an interim basis. Due to the subsequent reduced capacity in the Charitable Funds and Charitable Partnerships Support team, the actions have not been completed in the anticipated timescale. The revised timeline to improve the process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is as follows: Q4 2023/24: introduce new application summary template to highlight clear outcomes and outputs for all funding requests, which can be monitored and evaluated; Q4 2023/24 introduce new online application system for all funding requests and update guidance for all charitable funding applicants; Q2 2024/25 introduce a more sophisticated online system to monitor and record updates and evaluations from applicants to be included in Charitable Funds Committee reports and charity communications (subject to the approval of new systems Enhuse charity marketing platform, Donorly CRM, and ProGrant / other grant management system by IT & IG). Grant Management is now a standing item within the Team Update paper submitted to the quarterly CFC meetings.	Kirsty Thomson, Head of Fundraising - Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2023	31/07/2024	1	No

203	PFIG	Internal Audit	Delivery of Health Board Savings	2023	Limited	High	Transformational Savings and the establishment of the Transformational Team	The Health Board: • Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings. • Reviews the role of the Transformational Team in driving service change and savings.	Work continues on development and ownership of transformational savings for the 2024/25 financial year and beyond (as part of planning formation).	The Special Measures deliverable on allocation of the Transformation and Improvement resource is now complete, with available resource being allocated to the interim Exec Director of Operations and Executive Director of Public Health (MHLD) portfolios. The focus of their work is being driven by these teams to support the organisation's priorities, closer to the point of service delivery. The Portfolio Office continues to support central coordination of Special Measures and will continue to do so. The EDC for Transformation provides oversight of this allocation with a specific remit to ensure that allocations remain aligned with organisational transformational priority.	Update from Paulo Tardivel - The previous update still stands in relation to the part of this recommendation around the role of the Transformation and Improvement team - this part should now be closed. The first part of the recommendation relates to identifying financial savings opportunities and should remain with the Finance team. Update from Russell Caldicott - Update provided as part of savings review by IA Wales	Paula Dixon, Head of Financial Improvement	Russell Caldicott, Interim Executive Director of Finance	Started	30/04/2023	31/07/2024	1	No
206	QSE	Internal Audit	MH&LD	2023	Reasonable	High	Ligature remediation funding was allocated appropriately	MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	Each MH&LD SLT to establish a local Ligature Reduction Group, chaired by the Head of Operations, Vice Chair Head of Nursing with an agreed standardised TOR signed off. To review TOR of the newly established Divisional Ligature Reduction Group, to ensure appropriate membership, meeting frequency and reporting of the group is discussed, agreed and signed off. The Chair of each MH&LD local Ligature Reduction Group to provide an exception report to the Divisional Ligature Reduction Group, covering the following: annual review status evidence of monthly review risk control and mitigation progress aligned to external review recommendations. The Chair of the Divisional Ligature Reduction Group to provide an exception report to the MH&LD Divisional Service Quality Group (formally MH&LD QSE meeting, Tier 2) and to the MH&LD Senior Leadership Team meeting (formally DSLT Business meeting, Tier 1) to provide assurance on key risks and mitigation plans related to high, medium and low risks to ensure all ligature risk assessments remain subject to regular scrutiny. Chair of the MH&LD Divisional Service Quality Group to provide a monthly assurance report into MH&LD Senior Leadership Team meeting including high risk anti-ligature works for any required capital expenditure. MH&LD Division to commission an external review of all MH&LD inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Each local Ligature Reduction Group to report on progress aligned to the external review report recommendations, included within Chair's exception report feeding into the Divisional Ligature Risk Reduction meeting. MH&LD Division to arrange an audit to check the governance arrangements for anti-ligature are implemented and consistently being met, with an exception report being fed into Divisional Ligature Reduction group highlighting any variance aligned to standards.	The Division has received all external commissioned ligature reports and together with the internal ligature assessments are completing an analysis of high, medium and low scoring ligature items. The Division has held a meeting with Estates and Health and Safety to identify additional ligature items for capital investment/revenue. The Division has completed the fieldwork of the anti-ligature governance audit with a report expected early-mid December 2023.	The Division has a list of high, medium and low ligature risks compiled from external and internal reports. The Division to progress recommendations from the external reports, work to identify these items that require capital and revenue funding remains on-going.	Adrienne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Started	30/06/2023	31/03/2024	2	No
207	QSE	Internal Audit	MH&LD	2023	Reasonable	Medium	Appropriate governance arrangements in place	TORs require a review for signature and dates, OLM approval of draft TOR, development of a TOR for summit meetings. Formal reporting of information through the tiers is required, consideration needs to be given as using Divisional QSE as an exemplar. Cycle of business needs completion this will underpin any formal reporting requirements from the tiers.	Review TORs highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Summit meeting, MH&LD Finance and Performance Group MH&LD Clinical Strategy Group. To ensure, upon agreement of the revised Cycle of Business, all TORs are reviewed aligned to agreed Governance Framework of the new MH&LD Operating Model. Formal reporting throughout all meeting tiers to be implemented, with all meeting Agenda's amended aligned to agreed reporting structure. MH&LD Cycle of Business populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chairs Assurance reports template or Exceptions report template included for reporting throughout tiered governance framework structure.	MH&LD Governance Framework and Reporting Cycle developed and due for approval through respective governance routes. Due for presentation at Operational Leadership Meeting on 15/02/2024, and onward approval at Divisional Senior Leadership Team meeting on 20/02/2024. Once approved, evidence will be submitted and action closed.	MH&LD Governance Framework and Reporting Cycle approval delayed. Due for presentation at Operational Leadership Meeting on 15/02/2024, and onward approval at Divisional Senior Leadership Team meeting on 20/02/2024. Once approved, evidence will be submitted and action closed.	Adrienne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Started	30/04/2023	29/02/2024	2	No
210	PFIG	Wales Audit Office	Audit Wales CHC follow-up	2022	Reasonable	High	CHC Service Delivery	Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered.	The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development. Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical and Enabling Services and Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group.	There has been some progress against this action to ensure the Health Board is operating in line with the Framework. Key areas have been reviewed to ensure consistency across the 3 IHCs and Mental Health, and improved processes to provide greater assurance have been implemented e.g. Escalation Process and funding by exception. Further areas for focus have been identified and will be implemented and monitored as part of continued progress.	A number of task and finish groups have concluded on a number of areas to ensure that there is consistency across the 3 IHCs and MH&LD e.g. Placing in Care homes by exception, Disputes process, Training and education. Other workstreams around consistency of approach in regards to complex care, managing back log of reviews, fees queries and section 117 continue. Since the Audit, the executive lead has been confirmed and the work is progressing by identifying work programmes for improvement as opposed to a whole system approach. National work has also commenced in relation to CHC efficiencies, roles, competencies and structures. It is recommended this action target date be extended, continue to embed the improvement programmes and await the recommendations from the national team.	Jane Trowman, Head of Strategy and Health Planning	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2023	30/06/2024	2	No
215	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	Medium	Data reconciliation	3.1 Management to ensure reconciliation of reported performance information to source data is documented and retained. This could be incorporated within existing working documents. 3.2 Health Board to consider using UPPC engagement data to target promotion of the service to GP Practices that have low referral rates / have not used the service.	3.1 Review of reconciliation data for West and inaccuracies corrected. Confirm management arrangements for reconciliation and retention of performance data for Central IHC UPPC in line with findings and recommendations. Please refer to UPPC Peer review Action Plan – IA2. 3.2 Continuous review of GP practices that have not used the service and meetings/discussions to take place where necessary. Continuous attendance at Practice Managers/Cluster Meetings to promote and provide update of engagement. Review of ED referrals in the West to understand limitations, and consider relocation if proximity to ED is identified as an issue. Please refer to UPPC Peer review Action Plan – IA2	Update required	This was completed in 2023 and the recommendation was to look for alternative locations outside of the YG site. Unfortunately no suitable alternative locations have been identified and we are currently focussing on the review of the wider UPPC service to consider next steps. Revised implementation date listed in terms of the agreement of future model, with transition to follow.	Chris Couchman, Associate Director of Primary Care	Adele Gittos, Interim Executive Director of Operations	Started	31/05/2023	30/04/2024	1	No
217	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	High	UPPC Models	The Health Board should consider the future model of the UPPCs to ensure appropriate resources and accommodation are available to provide a consistent service that is accessible to all patients.	Future model for Urgent Primary Care being developed currently, led by the Director of Primary and Community Care and Deputy Executive Medical Director for Primary Care. The future model will be established as part of this work. Please refer to UPPC Peer Review Action Plan – IA3	Update required	Since this work began, advice has been received that the national funding stream for UPPCs will not be available and an exit strategy for alternative models or business as usual must be developed. 30th November initial workshop for all IHCs to discuss the future of UPPC models. Followed by West 25th Jan from which a paper has been circulated to stakeholders. East and Centre TBA. The review of out of hospital urgent care highlights not only how complex out of hospital urgent care is but how unnecessarily complicated it is. It showed that the complexity is costly and is potentially a cause of under use and inappropriate use of resources. The current action plan supports improvement within the existing model but it does not address the need to redesign a sustainable out of hospital urgent care services that meets needs. February 2024 a working group has been established to develop a business case and a paper is being drafted for Executive discussion.	Karen Higgins, Director of Primary Care	Adele Gittos, Interim Executive Director of Operations	Started	01/01/2024	31/03/2025	1	No
220	QSE	Internal Audit	Public Health - Smoke free sites	2023	Reasonable	Medium	MHLDs Training	MHLDs Division needs to establish how many staff require VBA training. Clarification is necessary on what training is required with regards to talking about the various NRT options to patients. Confirmation by the MHLDs Division that if the contraindications/medical interaction training is not taking place, what is the requirement to meet objective 15. *Admitting practitioners and other relevant staff are aware of contraindications/interactions of using certain types of NRT*. All the above must be reflected in the action plan.	Establish a NRT Training Task and Finish Group to explore and update the 'Guidebook' guidance and recommendation for who needs to complete Level 1 and Level 2 training in MHLD Division. This will determine how many staff are required to complete the training. Recommendation from Task and Finish Group to be received by the MHLD Division Training and Development Group for ratification and recommendation to Operational Leadership Meeting. The Task and Finish Group to consider training required for NRT options to patients. To include mechanism for recording training data to enable monitor and review. The Task and Finish Group will consider how best to address training, if this is required on contraindications/medical interactions training or if this recommendation is best addressed via completion of audit or distribution of information to raise awareness in the prescribing of NRT. The outcome from 2.1a, 2.1b, 2.1c will lead to development of a training plan for rollout across the Division. Completion of audit to assess awareness of NRT options for patients. Present outcome of audit to OLM to agree recommendations to ensure adherence with policy guidance.	The NRT audit report has been received on 30th November 2023, and will be submitted to the Smoking Cessation Group in December 2023, Clinical Effectiveness Group January 2024 and then a presentation on the NRT audit combined with the Help Me Quit survey at the MHLD Learning Event on the 19th January 2024.	The Help Me Quit survey report was received in the summer of 2023. The NRT audit was received towards the latter part of 2023. The NRT audit has been received by the Clinical Effectiveness Group in January 2024. The next step is for the NRT audit and the Help Me Quit survey to be presented at the Learning Event in February 2024 by the 2 report authors.	Adrian Jones, Assistant Director of Nursing MHLD	Teresa Owen, Health Board Lead for MHLD and Welsh language	Started	31/01/2024	31/03/2024	1	No

226	PFIG	Internal Audit	Continuing Healthcare Arrangements	2020	N/A	High	R3	The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by current and new CHC team members.	The CHC corporate team will lead the design of core structures for operational teams at Area and divisional level. This will include standardised job descriptions and structures on teams can work towards locally as opportunities allow within employment law.	Implementation date extended to 31st March 2024 as action is pending national work.	Some job roles have been standardized including the CHC operational managers roles, but other work pending subject to the National work. National work has also commenced in relation to CHC efficiencies, roles, competencies and structures. It is therefore recommended this action be closed / paused - continuing to embed the improvement programmes into business as usual and await the recommendations from the national team.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2021	30/06/2024	12	No	
227	PFIG	Internal Audit	Continuing Healthcare Arrangements	2020	N/A	High	R5	The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.	The Health Board accepts the need for the development of a new 'Commissioning Unit' with the responsibility for the strategic commissioning and performance management of all CHC and ICP placements. The Health Board has agreed in principle to adopt a 'Business Hub' model that will build on these principles, work has commenced to develop an outline business case.	Business Hub design principles have been prioritised and are being built into the current programme of work for Corporate CHC, Finance and Contracting. A weekly Corporate Provider Issues meeting has been established, with a monthly operational meeting to review themes, lessons learnt and identify areas for priority work. SOP provided as additional evidence. Action extended to 31st March 2024.	A number of task and finish groups have concluded on a number of areas to ensure that there is a focus on 'commissioning roles and responsibilities. As there is no resource to establish a bespoke team, Corporate CHC Contracting / Finance / Operational teams will continue to support the improvement and efficiency work and embed into business as usual as part of a 'virtual commissioning unit'. Opportunities will be explored as part of staff turn over and development to ensure roles and responsibilities meet current demands and priorities. A number of elements which support the 'virtual commissioning hub' are part of corporate CHC annual work plan. The work plan includes work on: Fee setting and engagement. Pre-Placement Agreement and Individual Placement agreements. Managing the backlog of Reviews. Development of a Care Provider Commissioning strategy.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	30/04/2021	30/06/2024	10	No	
230	PFIG	Wales Audit Office	Structured Assessment (Phase 3) 2021	2021	N/A	High	R1b	Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.	The business case process is being updated and simplified and will include an assessment of: the relative efficiency of the specific service; what action has been considered to improve that efficiency ahead of the business case.	The independent planning review is due to conclude in the last quarter of the calendar year. Part of the governance and planning reviews outcome will be the requirement to review the business case process from an IHC local level to that of an BCU wide business case level with scrutiny panels and committees defined.	Updates provided to QEDG on a quarterly basis.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/01/2022	31/05/2024	6	No	
238	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R5	Efficiencies: Service efficiencies – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.	Transformation needs to be supported by continuous improvement. There are already key enablers identified with each of the sites/localities developing and agreeing key service productivity improvements pulled together from a pan North Wales to ensure standards are improved and across the Health Board.	Integrated Ophthalmology MDT Local Networks refreshed: with successful delivery of Integrated Retinopathy Pathways, Clinical engagement negatively impacted by continuation of long-term vacancies (Pan BCU Clinical Lead: 12 months, West Clinical Lead >36 months) and variation in appetite for Pan BCU/regional pathways. Shared vision is being supported by Office of Medical Director and Away Days in Q4.	This was originally an area that required Transformational support. However, the work and program have now moved on and is led by the operational teams. Update from Chris Stockport - Eye care improvement group now established with clinical representation to oversee and deliver necessary development of the north Wales service model with subsequent improvement initiatives.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2023	30/04/2024	3	No	
241	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R8	Eye care clinical leadership: Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	Both North Wales Ophthalmology and Optometry Clinical leads are vital to developing and driving improvement. Recently these posts have become vacant and it is key to replace not only these posts but clinical leadership across sites and across the major sub-specialties; this matrix can be reviewed and tested. Vertical leadership creates potential silos whilst a more recent view of pan North Wales pathway leadership could be explored.	Update required	Currently in discussion with a number of potential internal candidates with a view to making an appointment as soon as is practical and given current clinical commitments	Rhys Blake, Associate Director of Planned Care	Adelin Interim Executive Director of Operations	Started	31/03/2022	31/05/2024	6	No	
247	People Committee	Internal Audit	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	2023	Limited	High		Appointment of substantive IESP/YSM Posts	Management must ensure all appointments to IESP/YSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders. Management ensure that mandatory procurement training is in place for all Executive Directors and all staff involved in procurement, as required by Welsh Government Chief Executive, NHS Wales.	A new standard operating procedure, linked to a new WP1 safe recruitment policy, for all IESP/YSM appointments will be implemented. The new SOP will encompass reporting of compliance relating to Welsh Government instructions and Health Board standing orders, and will detail the lead officer for each area of responsibility. A new procurement training competence will be added to all IESP/YSM positions into ESR which will link to the training course needed to acquire the competence. This will be visible alongside all mandatory training for senior managers and enable effective reporting alongside all training requirements for the individuals.	The new SOP for YSM appointments has been approved through the policy development group and is expected to be ratified at the next REMCOM meeting in January 2024. The SOP became operational in August 2023 pending ratification. Procurement training for Executives has commenced and is due to be completed by the end of January 2024.	The SOP did not get on the agenda for the January REMCOM and will be presented now at the March REMCOM. There are still a number of outstanding Executives that require training and this will be resolved by end of February 2023. The implementation date will need to be amended to March 24 now.	All Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Started	31/07/2023	31/03/2024	3	No
252	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Board Assurance Framework	The process for reviewing and updating the BAF should be documented and implemented. The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions. The sections of the BAF should be fully completed. The level of detail in action plans should be reviewed to ensure there is sufficient information included to provide assurance to members that appropriate actions are in place to address risks identified.	Document the process for reviewing and updating the BAF with implementation date. Ensure objectives of the Health Board is incorporated into the BAF with focused actions. It is paramount that all sections of the BAF be completed for robust scrutiny and assurance. (see action 3.4 below). Review the action plans to ensure sufficient information is included in the BAF with appropriate actions.	The Board Assurance Framework has been completed along with action plans however is aligned to priorities and not objectives. This can be closed once objectives are reviewed in February.	Work is now underway on the key strategic objectives for the Health Board to adopt by 2024 (April) and a draft set has been identified that will be shared with Board members through the development of the Health Board's Annual Plan.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Started	30/08/2023	31/03/2024	2	No	
257	PFIG	Internal Audit	Planned Care Recovery and Transformation Group	2023	Limited	High	Reporting	Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups/Committee.	Reporting arrangements will be published once finalised with the programme initiation arrangements.	Update required	ToR to be ratified at Primary Care Programme Board March 2024	Rhys Blake, Associate Director of Planned Care	Adelin Interim Executive Director of Operations	Started	31/07/2023	31/03/2024	1	No	
259	QSE	Internal Audit	Data analysis – Triangulation of data	2023	Limited	High	Template minimum data sets	The three Clinical Executive Directors stipulate the minimum quality and safety data sets for regular reporting across the Health Board, with respective Clinical Directors determining the remaining service-specific data required. The Deputy Director of Quality should ensure the minimum quality and safety data sets are consistently used across all IHCs and Divisions.	A standardised organisation-wide Quality Dashboard is under development. A Workshop will be held with members of the Quality Delivery Group to agree the content of reporting from IHC/Divisional quality groups to the executive chaired meeting. This will inform reporting requirements throughout the quality governance structure. Once the above is agreed by the workshop and executive-chaired Quality Delivery Group, standard templates will be issued to divisions.	The Clinical Governance Review as part of Special Measures has not yet commenced and this work will be done as part of that review process with support from the national team; deadline therefore extended to 31/03/2024.	Work continues as per the previous update. The draft dashboard is in place and being further refined, invalidating the data fields. An initial automatic data feed into the warehouse has not been established.	Matthew Joyce, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/09/2023	31/03/2024	1	No	
261	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Process management	Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning performance management, business intelligence/analysis and other professional services that input to contract management both where the health board is commissioner and provider. The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. (Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight).	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Pending	31/08/2023	31/03/2024	2	No	

262	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Contractual obligations	Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective.	The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establishing the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective.	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Pending	31/08/2023	31/03/2024	1	No
263	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Quality measures (a)	Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements (by 30/08/23). The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025 (by 31/03/2024). The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner/CQC (by 31/07/2023).	For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements (by 30/08/2023). The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025 (by 31/03/2024). The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner / CQC (by 31/07/2023).	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Pending	31/03/2024		0	No
264	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Quality measures (b)	Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required.	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Exec Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Exec Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Pending	31/10/2023	31/03/2024	1	No
265	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Board assurance	Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF (by 31/10/2023). The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation routes (by 31/08/2023).	The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required.	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Pending	31/10/2023	31/03/2024	1	No
267	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Procedures	1. Standard Operating Procedures should be in place for the process of collating information for the performance reports, including: - Roles and responsibilities (Performance staff, informatics, other staff providing data) - Data quality standards/consistent metrics/timeliness - Data collation – process for receiving/extracting and collating data (including systems used and any training required for these) - Data validation – details of checks to be undertaken 2. Further work is required to provide assurance to the Board that the actions stated in performance reports are improving performance/outcomes.	1. The proposed establishment of a working group between Performance and Informatics colleagues is being developed – the first meeting of this meeting will focus on the process of external reporting of data, alignment with Wales Digital reporting guidance and other data definitions used within the NHS Wales Operating Framework and Welsh Government Aims. The remit of the Group will include all of the recommendations made in this report. 2. Agree – The documents editor has the responsibility to ensure all avenues of intelligence and assurance are incorporated into the analysis and reporting including external assurance if available.	Once the IPR is ratified at Health Board on the 30/11/2023, the Performance Intelligence and Assurance Directorate will produce the Standard Operating Procedures required to ensure efficient and accurate replication of the reports for updates as required. The Standard Operating Procedures will be tested and the Directorate will encourage a review by internal audit to ensure that they are robust and appropriate for a business continuity plan.	Procedures for data capture can be evidenced by the Director of Performance, the reporting cycles now in operation following endorsement of the Performance Framework.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2024		0	No
270	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Accountability meetings (c)	The process for reviewing actions should be revisited, to ensure actions from meetings are SMART, and progress is regularly provided (with reference to further detail in meeting minutes as required)	This action will be aligned with the revised PAF process for Q2 Reviews, scheduled for Sept 2023.	The Integrated Performance Strategy for 2023-27 will outline the communication routes with regards accountability reviews. This will include the structure and process around recording and communicating the actions and outcomes of the reviews. There will be a clear escalation process and pathways ensuring escalations reach the appropriate forum, e.g QSE, PFIG. They will also ensure timely communication and feedback to the services being held to account, with clear SMART actions. Progress of such actions will be monitored by the Performance Intelligence and Assurance Directorate outside of the reviews to ensure progress and updates are available at the next review.	Accountability meetings are the Integrated Performance Reviews, cancelled owing to Industrial Action. The DoP, EDoF and CEO are reviewing the ToR for the IPRs and will have the dates set for the next financial year, by 31st March 2024. Whilst initial meetings occurred for some areas, they were chaired by relevant Operational Director and the meetings need to develop focus to hold services accountable for delivery. This is to be considered in the review of how these meetings progress.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2023	30/06/2024	2	No
276	PFIG	Internal Audit	Accounts Receivable	2023	Reasonable	Medium	Financial Procedures	Management review and update relevant financial procedures as necessary to ensure they are fit for purpose	The updating of financial procedures is part of the Financial Control Environment Action Plan. Those requiring review will be prioritised and brought up to date as required.	Reasons for delay: • The audit of the 2022-23 annual accounts took a month longer than originally planned in the Welsh Government timetable and was not completed until the end of August. • Rather than looking at a standard update of the existing financial procedures we are carrying out a larger review to consider whether any can be consolidated or simplified which will take longer but will in more user-friendly formats, see member update: “The four financial procedures have now been drafted and a meeting is being arranged with the Policies Team to agree the necessary consultation and approval processes before the procedure can be adopted”. It is expected that implementation will be January 2024.	A review programme has been established to refresh the Financial Policies, with consideration being given to re-assessing those as local procedures, as appropriate. The first two policies are currently out for local consultation, with the next two due to be consulted upon in late February	Simon Weaver, Head of Financial Control	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2023	28/02/2024	1	No

286	PIIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.3)	Management to review implemented improvement actions to ensure they are operating as expected/having the desired impact.	Agree with recommendation. Management will review implemented improvement actions to ensure they are operating as expected/having the desired impact.	Update required	This action is ongoing and in process. As actions are completed they will be monitored by the Primary Care Team. The outstanding actions will be monitored closely and will be reviewed when completed to ensure they are operating as expected.	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	20/10/2023	31/03/2024	1	No
288	PIIG	Internal Audit	GP Out of Hours	2023	Limited	High	Data Discrepancy	Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.	Agree with recommendation. Management will clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. The BCU team will work with the national team to agree on the content and presentation of the appropriate data sets.	Update required	Investigation into data discrepancy has shown that the Health Board GPOOH data is accurate. The National Team had applied floored formulas in accumulation of data, and were also not using the same filter set to ensure accurate data collection. It was also found that a report used by the national team was not pulling the full data required on certain fields that was being captured by the GPOOH team. A request is with Adastra to correct this but has been delayed due to the contract agreement only in place from 1st January. HB GPOOH Team and National Team will continue to work together to ensure the remote data being pulled is uniformly accurate. The HB have asked Adastra for an update on the report fix, and therefore have revised the implementation date to allow for this. Following this, it will be an ongoing piece of work to check month on month.	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023	31/03/2024	0	No
289	PIIG	Internal Audit	GP Out of Hours	2023	Limited	High	Board Assurance	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.	Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team.	Update required	This action is ongoing and in process. Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review.	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023		0	No
296	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1b To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.	The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: - the Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile.	Auto population dependent on All Wales schedule, however risk mitigated via training resources and peer review process.	Ongoing national agenda: This is part of the national agenda, Health Board representative CNO aware of the recommendation and represent Health Board.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/02/2024	30/04/2024	1	No
298	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1a To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.	The Manual handling Advisors are undertaking a monthly visit to wards identified as high risk for falls based on datix data. This programme is working well in Central and in the East and due to sickness there has been a delay with establishing this programme in the West. MH Trainers also attend wards to check compliance training classes are cancelled or reduced size requiring only one trainer. It should be noted that the MH bedside learning programme is limited to the one visit a month, there are other teams that also provide this learning though and this may benefit from a coordinated response.	FBHMA is discussed during all training delivered by the Manual Handling team. Each region of the Health Board is supported by a dedicated Manual Handling Advisor who is instructed to deliver falls bedside learning at least once per month. This workstream is monitored by the Manual Handling Manager and forms part of the teams annual KPI's. Due to sickness in Q2 & Q3 2023/24 operational demand has resulted in Manual Handling Advisors supporting the wider team with the delivery of all other aspects of Manual Handling training.	Sue Morgan, Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/01/2024	31/03/2024	1	No
299	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1b Review Safeguarding training to include post falls management.	Internal training facilities to be identified by each IHC by December 2023. MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023.	Internal BCUHB training rooms have been identified in BCUHB site including BYN, Abergele and the CTU in Wrexham. Moves are scheduled in to the diary to take place by the end of 2023.	Conversations are being undertaken to ascertain the possibility of incorporating post falls management into Safeguarding training via the All Wales Safeguarding Group. Local implementation of this incorporation will commence in April 2024	Sue Morgan, Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/12/2023	30/04/2024	1	No
300	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1c Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.	Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals. Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls.	Email reminders are being sent to staff four weeks prior to them attending their course and then a week before. Any delegates who do not attend (DNA) are sent a survey to establish the reason so that this can be captured in future training plans. The team are in the process of setting up the text message reminders. Level 2 training remains an elearning package centralised to Welsh government, the package does not directly talk about falls but does support staff of when to consider an adult at risk. There is a guidance framework that is available for staff to refer to in relation to falls and safeguarding. This has also been adopted by the North Wales Safeguarding Board.	Regarding the bedside learning and training challenges in Patient Handling due to vacancies and absence rates within the Patient Handling and Health & Safety team. This has been added to the Risk Register. Alternative support is being sourced from practice development teams.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	03/04/2024		0	No
304	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.	SOP to be developed.	SOP in final stages of development as best practice guide and flow chart to support weekly meetings. The IHCs are currently testing the use of Crits sheet to support falls reviews, learning and sharing. A member of the Patient Safety team attends IHC weekly meetings to support the process and offer additional IHC support.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/12/2023	30/03/2024	1	No
307	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1c Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.	4.1c The ward accreditation metrics are currently under review as part of the Health Board Ward Accreditation review. The revised metrics will be tested across the Health Board inpatient wards to confirm the appropriateness and level of detail within the metric.	Aiming for April 2024 relaunch of Accreditation programme.	Proposed new Ward Accreditation metrics are being used for the supportive visits to wards to establish areas requiring additional support for wards prior to the relaunch of Accreditation programme later this year launch date to be confirmed. Health Board DDNT team are currently developing a data capture tool that will link in with HB Quality Dashboard and will enable wards to provide evidence against the Accreditation metrics.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/04/2024		0	No

313	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 6 – Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.	Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.	These figures are submitted to WG on a weekly basis and also discussed in the weekly access meetings. The validation exercise had concluded. Long waiting patients (named Extreme Waits) are monitored weekly through Corporate Access (following local IHC Access weekly meetings that inform Corporate Access) with weekly updates provided to Welsh Government. As well as this (the monitoring of Extreme waits) the health board also reviews weekly Treat in Turn and the reduction of long waits this being >104 week waits and new outpatient referrals >52 weeks. As part of data quality, the health board has a continuing cycle of validation, this consisting of a two phased approach (data, and two stage patient contact) that has both clinical and Welsh Government approval.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022		0	No
317	PFIG	Internal Audit	Decarbonisation	2023	Limited	High	Matter Arising 1: Governance Structure (Design), Monitoring & Reporting (Operation)	In accordance with the NHS Wales Decarbonisation Strategic Development Plan 2023-2030, establish appropriate, robust, and effective governance frameworks to implement the Health Board's Decarbonisation Action Plan to achieve net zero carbon emissions by 2030.	As articulated in the findings of the report the Health Board has formed an appropriate governance framework. The six subgroups formed aligns to the national recommendations and reports into the DPB which will then report to PPH and the Board receiving assurance from this sub-committee. There is an acceptance of the infancy in which this framework has been formed and we will need to ensure the sub-groups offer the appropriate level of assurance to the DPB. The Decarbonisation Programme Board will ensure a formal governance framework is defined and agreed through the Terms of Reference. In addition this will align to the overall organisational governance structure, with reporting to PPH once re-convened.	Governance framework enacted for 2024/25 with addition of PPHH Health Board sub-committee to oversee work in this area and highlight improvements made and risks to delivery accordingly.	Russell Caldwellcott, Interim Executive Director of Finance and Programme Lead	Russell Caldwellcott, Interim Executive Director of Finance	Started	31/05/2024	31/07/2024	1	No	
319	PFIG	Internal Audit	Decarbonisation	2023	Limited	High	Matter Arising 2: Project Delivery (Design / Operation)	To complete the actions within the specified timeframe, greater focus and scrutiny is required on the action plan.	The Health Board is currently part of the discussions as all actions, timeframes and targets are being reviewed Welsh Government. The Decarbonisation Programme Board do monitor those actions at risk however in the current financial climate all actions will be reviewed and prioritised accordingly to understand what can be implemented and actioned with a realistic timeframe.	Discussion is still ongoing with the Health Board going to tender for the Re-fit programme in January 2024. In addition, this element will be referenced within the development of the plans for IIMP moving forwards in conjunction with the Planning, Transformation and Improvement Directorate.	Russell Caldwellcott, Interim Executive Director of Finance and Programme Lead	Russell Caldwellcott, Interim Executive Director of Finance	Started	31/05/2024		0	No	
320	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to establish robust policy, guidance, or Standard Operating Procedure to support operational processes. Governance, reporting, and escalation requirements to be clearly defined.	A Putting Things Right (PTR) and Learning Policy will be developed to give clear guidance of operational processes, governance reporting and escalation requirements when learning is identified.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	The draft policy is under development and will be completed by the end of February and submitted for approval.	Matthew Joyce, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	Started	29/02/2024		0	No
324	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to review implemented learning to ensure effectiveness.	The Quality Informatics and Learning Team will work with Clinical Effectiveness Team to explore how learning can be reviewed/audited as part of the learning cycle and feed into the annual audit cycle. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	The work is underway to complete this work with meetings arranged between teams.	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024		0	No
326	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to review implemented learning to ensure effectiveness.	A new, digital repository of learning and cascade system will be developed. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	The work is underway to complete this work. A developer has been assigned to this work and several workshops with clinical and corporate staff have been held to develop the project.	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024		0	No
327	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 2: Make it Safe (Plus) (Design)	Management to formally document and communicate the principles and requirements of Make it Safe (Plus) to ensure consistency across the Health Board. Governance, reporting, and escalation requirements to be clearly defined.	A full review of the incident process and procedure has been commenced, which will be co-designed with staff to ensure that the new procedure is fit for purpose and workable for staff undertaking rapid reviews/investigations and learning.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	The Patient Safety Team (PST) have conducted a scoping and engagement exercise across all the Integrated Health Communities (IHC) and Divisions to establish 'local priorities' along with current practices and processes in place, and to establish good practice which can be shared and utilised across the Health Board. In addition, identification of areas which require attention and/or improvement, including where there is a requirement to avoid duplication and where variation is a factor were determined. The outcomes of these engagement events were summarised into a proposal for the Health Board Patient Safety Group with an ask to review and feedback any additional thoughts or comments to finalise the paper for submission to the next QDG.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024		0	No
328	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 2: Make it Safe (Plus) (Design)	Management to ensure all Make it Safe (Plus) reviews are documented and recorded appropriately i.e. through regular audit / review.	The Patient Safety Team (PST) review and report on completion of MIS Plus and timescales. This information is shared with services. The PST will undertake a weekly audit/review to provide assurance that reviews are documented and recorded appropriately.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	Following initial audits in August 2023, monthly audits continue with incidents without the MIS+ completed identified and reported back to Governance Leads and Nurse Directors	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024		0	No
329	QSE	Internal Audit	Adult and Older Persons Mental Health Unit	2023	Reasonable	High	Matter Arising 4: Electrical Infrastructure (Design / Operation)	At future projects The UHB should seek to understand how this issue was only identified as a serious risk at a late stage. This learning should be applied to all future schemes the UHB undertake to ensure that issues such as this do not have the potential to derail future projects.	It was documented within the Estates Annex that was submitted for the OBC that the Health Board were arranging a separate project to increase electrical capacity. At the time this was only minimally increased due to availability within the network and did not increase to the extent required. Net zero targets have also had a major impact on the scheme. A Meeting is arranged with WG to discuss the option of a separate business case submission to resolve Electrical Infrastructure.  The Health Board have reviewed learning that can be applied to future schemes. At key project stages, service infrastructure will be reviewed in relation to the project and the site development control plan.  Key drivers will be: 1) To update existing Development Control Plans to align to Estates Strategy. 2) To fully understand and monitor site services infrastructure in terms of capacity and compliance for each site.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	WG have supported fee to develop business case for the YGC electrical infrastructure upgrade. Detailed design ongoing. Project core team and project board commenced. The IHC is due for submission to WG in September 2024, ensuring electrical capacity is aligned to the ADPMH scheme. The update DCP will be updated as part of the work stream. Evidence of lessons learnt on other capital projects, examples being, Llandudno Orthopaedics and Wrexham Continuity.	Daniel Eyre, Head of Capital Development	Teresa Owen, Health Board Lead for MHD and Welsh Language	Started	27/11/2023		0	No

**AUDIT COMMITTEE**  
**AUDIT TRACKER - ALL RECOMMENDATIONS PROPOSED FOR CLOSURE**

ID	Committee	Internal Audit (IA)/ Wales Audit Office (WAO)	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Update provided to 12/01/2024 Audit Committee	Update for 15/03/2024 Audit Committee	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions
57	QSE	Internal Audit	Quality Improvement Strategy	2020	Limited	High	Reporting progress of Quality Improvement Strategy (QIS)	For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: Is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan.	The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones, that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE.	This action remains on track and was subject to discussion at the Quality Governance Round Table Meeting with Welsh Government in November 2023, and forms part of the 2023/24 business plan for the Quality Governance Department.	The new CEO has confirmed the intention is to develop an integrated quality framework aligned to the Quality Management System, rather than a separate strategy. The QMS is a new statutory requirement of the Duty of Quality Measures Programme. As such this action is closed and the work will be taken forward as part of Special Measures and the Duty of Quality. An Executive Workshop has been held, as has a Senior Leadership Team Workshop, and a Board Workshop is planned for Q4. Therefore, this action from 2020 is fully superseded by new legislation in 2023 and the new direction of the Health Board.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	01/08/2020	31/03/2024	11
114	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Declarations of Interest Compliance	3.1 Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required. 3.2 The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.	3.1 Governance Leads will be issued monthly reports highlighting their teams' compliance with DOI submissions, which will form part of their monthly governance meetings, and escalated to the appropriate Execs Delivery Group on a bi-monthly basis. An automated approach to DOI management is being pursued via the MES Declare system, with the aim of ensuring that this is in place from the 1st of April 2022. This will also be supported by a communications plan and a refreshed FAQ page. As part of the planned communications plan, staff will be reminded of their obligations to disclose gifts and hospitality offered and received (onto the MES Declare system) under the Standards of Business Conduct Policy. This will also feed into the assurance monitoring by governance leads, which will include pursuing unauthorised declarations and escalate non-compliance of staff for known Gifts and Hospitality received, but which they have not declared.	MS Declare is now live for both Declaration of Interests and Gifts and Hospitality. All members of staff have been issued individual emails and log in details of how to make a declaration. The Declarations sharepoint site has been updated. Staff are reminded regularly to submit and we have received a targeted email list of Band 8a and above to enable a personalised email from the Office of the Board Secretary office to be sent to these individuals. The action to remain open until the Declare System is fully embedded.	The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for Standards of Business Conduct will highlight future areas of focus. This is still in its first year of infancy and we appreciate that there will be future improvements to be made but original action now closed. Copy of Audit Committee agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/06/2022	31/01/2024	3
115	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	Medium	Declarations of Interest Compliance	1.1 The Standards of Business Conduct policy is reviewed and updated where required, including further information: <ul style="list-style-type: none"> <li>Those roles below band 8c that require a declaration of interest</li> <li>Responsibilities of Governance Leads to ensure compliance within their areas Medium Standards of Business Conduct Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 12</li> <li>Monitoring and reporting arrangements</li> </ul>	Agreed, the policy has been updated with a view to incorporating best practice identified from the All-Wales Standards of business conduct Policy as well as the requirement for all staff to submit a declaration of interest annually.	The policy has been updated and is due for review in 2025. However, the policy will be reviewed again sooner than 2025 due to an audit this month, and the policy remains ambiguous. There is further work to be undertaken with Governance Leads to ensure they are aware of how to review Declaration of Interest. All staff have been targeted to complete a Declaration of Interest and Gift and Hospitality, however, further work will be undertaken, and Band 8a and above will also be targeted by an email from the Office of the Board Secretary. The action to remain open until the Declare System is fully embedded.	The action that was prescribed in 2022 has been completed and the policy is due to be reviewed in 2025. As such the original action can be closed as we recognise that the 2024 internal audit for standards of business conduct may require further action. Copy of policy provided as evidence for closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/06/2022	31/01/2024	1
116	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Declarations of Interest System	2.1 The Office of the Board Secretary should seek confirmation from Finance that this information has been updated on a regular basis, to ensure compliance can be accurately monitored. 2.2 Exception reporting should be produced and reviewed regularly to highlight any issues with the data and the impact on compliance rates.	2.1 Agreed, however a new system is being put in place with effect from April 2022, which will be managed directly by the Office of the Board Secretary, and monthly updates from ESR will be incorporated onto the MES Declare system to ensure its accuracy and completeness. 2.2 Exception reports will be generated on a monthly basis on the new system, and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late.	The next report will be provided to Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded.	The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. A meeting is to take place to ensure that mismatched information between Declare and ESR can be solved. However, the original action has been closed. Copy of Audit Committee agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/06/2022	31/01/2024	3
117	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	Medium	Gifts and Hospitality requirements	4.1 The guidance regarding the process of accepting/declaring gifts as well as Hospitality should be circulated/highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors/Assistant Directors of their role in approving hospitality prior to acceptance.	Agreed, a communications plan will be put in place to publicise the importance of disclosure of gifts and hospitality as part of the process of raising awareness on the requirements of the Standards of business Conduct Policy. (Consideration is also being given in relation to making the process of accepting / declaring gifts as well as Hospitality and the submission of an annual declaration of interests (even a Zero return), to be recorded as part of employees' Annual appraisal process. The level of compliance can then be monitored from the systems where the Annual Assessment or PADR is recorded. The feasibility of this approach is being considered.)	This process was implemented when MES Declare went live. A report will be received at the Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded.	The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. Copy of Audit Committee agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/06/2022	31/01/2024	2
118	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Monitoring and Reporting arrangements	The Office of the Board Secretary to consider the monitoring arrangements in place for declarations, gifts and hospitality to ensure these are reviewed on a regular basis. 5.2 Reporting to the Audit Committee to be updated to include current compliance rates for DOIs. Consideration should be given to more regular reporting if compliance rates are generally low.	5.1 DOI monitoring will take place monthly with scope incorporating: The completeness of the disclosures for decision makers, Quality assurance checks on submissions, Significantly out of date disclosures requiring escalation, Monthly update of ESR starters and leavers data, DOI disclosures requiring follow-up action. Gifts and hospitality declaration monitoring: Where appropriate, Governance Leads will also be assigned the same responsibilities for DOI reports to be monitored by the Office of the Board Secretary on a bi-monthly basis, with compliance rates to be reported to Audit Committee on a quarterly basis, by the Office of Board Secretary. The annual report on gifts and hospitality will be submitted to the Audit Committee in order to evidence compliance.	The system is now in place and a number of reports have been drawn down. The Board Secretary and Head of Corporate Affairs will review what data is required to be presented at the Meeting in January 2024. The action to remain open until the Declare System is fully embedded.	The Declare system is now embedded and work to continually improve and monitor is in place. The 2024 internal audit for standards of business conduct will highlight future areas of focus. Copy of Audit Committee agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	31/05/2022	31/01/2024	3

169	QSE	Internal Audit	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	2022	Limited	High	Policy and Management of Website Information	1.1 Health Board to establish formal policy to support the management of the Health Board website (and other digital) content. 1.2 Management review website user administrator access privileges and establish controls to ensure amendments or additions to the Health Board website are subject to review and scrutiny prior to publishing. 1.3 Management to establish controls or monitoring arrangements to ensure that changes published on the English web pages are also actioned on the Welsh pages.	1.1 Establish a formal policy and guidance to support the management of BCU digital channels, including the website. 1.2 Review current administration access to the BCU website and issue revised guidance and training where required. 1.2 Commission support to conduct a review of the website to identify and rectify any discrepancies with existing Welsh/English content. This will be a six-month project to provide a robust review of the website. This will be funded by the Corporate Communications Team. 1.2 Recruit a dedicated translator for the Corporate Communications Team to: manage all translation requests for the website ensure content is published simultaneously link with Welsh Language team to maintain translation standards. This will ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. The funding for the first 12 months of the post has been agreed, during which time a business case will be made for the post to be permanently established within the team. 1.2 All devolved editors will be contacted and reminded about the translation and publication requirements for the website and offered refresher training sessions. 1.3 Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website and resolve issues with delayed translation requests. 1.3 Establish a programme of audits to monitor the website on a monthly basis.	The draft report has been received back from the Auditors to confirm all actions have been completed. However, work is ongoing in order to undertake random checks on web pages to ensure continued compliance with protocol.	In terms of the website audit, the final report has now been received and shared confirming all actions were completed. The ongoing monitoring is part of our established control measures so if this is the reason this recommendation cannot be closed then it may remain permanently open as that monitoring will continue indefinitely.	Andrew Rogers, Head of Corporate Communications	Teresa Owen, Health Board Lead for MHL and Welsh Language	Final Client approved	31/03/2023	31/01/2024	4
172	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Finance	Management to identify and progress savings schemes as a matter of urgency. Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.	A revised control total has been set for the EHC. EHC is an exemplar area for CHC savings. The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022.	Update required	Monthly meetings are held with teams to identify, monitor and share learning around the savings targets. This has allowed us to progress CRES targets. There is a monthly finance and performance meeting for all areas to report into and new for 2024 is the deep dives into the areas. The chief finance officers are an integral part of the IHC meetings and input to all decision making.	Michelle Greene, Integrated Health Community Director (East)	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023	05/02/2024	1
175	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Risk Management	5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions/dates are included. 5.1b Management to review consistency of reporting in accordance with the revised Operating Model/governance structure.	EHC Risk Management Group have met twice to date. All level 1 and 2 risk discussed and divisions tasked to review all risks within own areas. Some risks sit within East are corporate risks and some sit within operational estates. Ongoing review of risks, Level 3 – Quarterly, Level 2 – Bi Monthly Level 1 – Monthly. Risks for Acute Site, Childrens, HMP Berwyn, Primary Care, Facilities and Community Services have been amalgamated into an EHC Integrated Risk Meeting, risk register currently under review.	Update required	There is now a Wxm site Risk meeting, this reports to East IHC Risk and Governance Meeting as per the requirements of RMO1, this has been in place since September TOR attached. The monthly meetings are minuted, have an up to date TOR (we are waiting the new revised RMO1 so that we can update the TOR). Copy of agenda and minutes provided as evidence for closure.	Ian Donnelly, Acute Care Director	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023		0
178	PFIG	Internal Audit	Effective Governance: YG	2022	Limited	High	Clinical audit	The list of Tier 3 audits should be shared with the QSCE to ensure there is no duplication of audits/efforts across the Ysbyty Gwynedd. This would also provide opportunities for work across more than one division/locality. Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions/localities are responsible for Tier 3 audits, we would suggest the learning/feedback is provided to the QSCE and the Clinical Effectiveness Team and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board. Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan.	A full list of Tier 3 audits will be Shared via the next Quality Safety and Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focussed and do not duplicate effort. Lessons learned from Tier 3 Audits to be a major item from discussion at the December 2022 QSCE, with all Directorates represented on a multi-disciplinary basis to ensure cross fertilisation of ideas and feedback. A report to be produced to consolidate this feedback to be shared via the Health Board level meeting in early 2023. All appropriate staff encouraged to participate in Tier 2 audits and contribute to clinical audit, where possible being given allocated time for this, via a joint letter from the clinical members of the new IHC Leadership Team (Medical, Nursing	Update required	A tier 3 audit programme has been developed for 2023-24. This was shared at the IHC's Quality Local Delivery Group on 31st October 2023. It is available on the Intranet based on those projects registered via the Clinical effectiveness portal. A weekly update on the delivery of tier 2 audits is also available on the Intranet. The audit and effectiveness monthly update that was shared at the Quality LDG on 28 <sup>th</sup> November 2023 is attached. A monthly report is now provided in this format to track progress and as a means of escalation. An update on Tier 1 audit compliance (as at 15 <sup>th</sup> January 2024) is attached, showing the west as the best performing IHC in relation to compliance (65% responded to in time, 22% response awaited but still in time, 9% no response and overdue.) Clinical teams are now better engaged with the process; for example the Surgical Directorate are about to commence a Consent to Treatment audit, and this will be reported through the Quality LDG. Downloads from the intranet detailing the current position can be shared for further assurance if required. Additional evidence relating to the audit provided as evidence for closure.	Jaww Hughes-Evans, Interim Area Nurse Director West	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/12/2022	31/03/2023	2
183	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Request and submission of papers and reports.	1.1 We recognise that the Health Board have recently implemented a Board/Committee Paper Assurance and Publication SOP. Management to ensure established timescales are met, monitor compliance, and escalate issues of significance to relevant Executive Leads, Chairs, and/or Board Secretary. 1.2 Management to consider publishing meeting and committee calendar on the Health Board website to encourage public engagement.	1.1 Agreed and as stated a Standard Operating Procedure for committee and board agendas is in place. 1.2 2023/24 Board and Committee meeting calendar will be published when finalised.	The Corporate Calendar is now in place and work is ongoing to produce the calendar for 2024-2025. The SOP is implemented. Although the original (2022) recommendations have been met, this will be monitored and should stay open until the remaining Committees are scheduled to give additional assurance to the Audit Committee.	The Corporate Calendar has now been finalised after agreement with the Chair of the Health Board and has now been published along with the Governance routes and dates. On the second part of the calendar there are detailed timelines on all Committees. The Corporate Calendars were published on BCUHB website on 09/02/2024, and a copy provided as evidence for closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	31/12/2022	31/03/2024	2
185	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Reporting Breaches.	Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.	3.1 All staff will be reminded of the requirement to complete the breach log in relevant cases. Internal Audit observation: We do not believe the management action mitigates the risk of inaccurate reporting to Audit Committee.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The Audit Committee received a paper on Breaches at its November 2023 meeting, this will continuously be monitored and reporting diligently monitored.	Close and reflect the breaches in context of special measures information on Health Board. Email from WG on Breaches and Audit Committee reports highlighting any breaches in November and January. Additional evidence from WG and Audit Wales provided to support closure	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	31/12/2022	31/12/2023	1

186	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Cycles of Business and Terms of Reference.	4.1 Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed and approved by relevant committees to ensure continued relevance. Approval should be recorded in relevant meeting minutes. 4.2 Management to consider publishing Board/Committee Terms of Reference and/or Cycles of Business on the Health Board website to promote public engagement and reintroduce the publishing of meeting minutes to improve accessibility.	4.1 Agreed. The ToR approved by Board in the September 2021 governance review are in the process of being reviewed and proposed to the committees and their approval will naturally be minuted. Committee Terms of reference will also be reviewed as part of the Board and Committee effectiveness review. 4.2 Agreed, these will be published on the website.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Whilst there is more work to do this year, the original action has been completed.	A new Committee structure is in place. The actions have been taken forward. New ToR and Calendar of Business have been approved and will be reviewed and received at each meeting. Additional evidence to support closure is the link to the Corporate Governance report where Committee structure was signed off in September 2023 and in Jan 2024, when ToR were agreed.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/03/2023	31/12/2023	1
187	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	High	Process Design	The Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally/request made to OBS/authorisation granted by IMs and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted.	1.1 The template will be amended as suggested to include the five additional fields. 1.2 Chair's Actions will be universally captured as part of the Chair's written report to the Board/Committee with effect from October 2022. 1.3 A review of the Terms of Reference for Board and Committees will be scheduled as part of the COB and Chair's Actions and will include the authority to undertake Chair's actions on behalf of the Board, as set out in the Scheme of Delegation	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward.	A Chairs Action protocol was put in place in 2022 and has recently been audited. It is now common practice for us not to routinely use Chair's Actions. There is evidence to show a record of Chairs actions in the Corporate Governance section of each Board report. Copy of Board agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	31/01/2023	29/02/2024	1
188	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	Medium	Standard Operating Procedure	The SOP should be updated to reflect the detail of the process in place and consideration given to which IMs should be included in the approval of the request, where possible using their area of expertise.	The SOP will be updated to ensure alignment with the current practice for Chairs Actions, including the criteria applied for Independent member selection, taking into account expertise, and appropriate committee remit	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward.	There is a SOP for Chairs Actions. It is now common practice for us not to routinely use Chair's Actions. All new TOR agreed at Board explain process and also the Board report has a section reporting Chairs Actions. Copy of Board agenda bundle provided as evidence to support closure.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	30/11/2022	29/02/2024	1
216	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	Medium	Governance Frameworks and Communication Strategies	Governance frameworks, Communication Strategies, and supporting documents should be periodically reviewed and approved to ensure continued relevance and alignment with wider Health Board strategies. Evidence of scrutiny and approval should be retained.	Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality and Safety Group. Please refer to UPCC Peer review Action Plan – IA1	Update required	An action plan is in place and is reviewed via the primary care leadership team which meets every month. Copy of Service Review Improvement Plan provided as additional evidence for closure	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/05/2023	31/03/2024	1
218	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	High	Benefits Realisation	2.1 Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2 The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated.	2.1 Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2 Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases.	Update required	Datasets are being used to support activity described in action 217	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	01/01/2024		0
235	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R2	Sub-regional variation of patient waits: Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	This links to recommendation 7 (Accountability for eye care service) so that a North Wales view can provide overview, guidance and management utilising the patient treatment list wait information that is already available supported by the dashboards that are in progress.	Update required	Governance established to support necessary service improvements. A Health Board wide Eye care improvement group now convenes on a monthly basis to oversee progress. Action can be closed as analysis of variation complete and has informed ongoing improvement work. Copy of update to QSE on Internal Audit Report: "Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists" provided as evidence for closure	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022	31/08/2023	6
240	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R7	Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency.	This will be encompassed within the stronger together work which will require the local integration of acute and primary care services with regards to the vertical pathways and processes whilst there is a North Wales responsibility and accountability for services and decision making to eliminate inappropriate sub-regional variation. It is anticipated that the introduction of a new Optometry reform contract will support change, strengthening relationships but also the opportunity to provide better accountability if delegated to the Health Board.	Update required	Health Board Eye improvement co-ordination group oversees improvement initiatives and prioritisation, supported by the BCU ophthalmology network structure now in place to support service reconfiguration and associated implementation of GIRFT and wider improvement recommendations	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022	30/11/2023	7
244	Audit Committee	Wales Audit Office	Structured Assessment 2019	2019	N/A	High	R1	Clinical strategy and service planning R1: Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: Medical staffing, vacancy gaps and on-call rota management. Service efficiency and affordability. Ability to meet forecasted growth in service demand. Mitigate the impact of unscheduled care on the effectiveness of wider services. Enabling sub-specialisation of clinical services, where beneficial.	A digitally enabled clinical strategy has been proposed and extensively discussed at health board meetings in September, October and November 2019. It sets out an ambitious approach to improving population health by focussing on prevention and systems changes, specifically establishing whole-system evidence based pathways; managed professional networks; and implementing a core bundle of digital healthcare technology, e.g. a digital health record. This strategy will disrupt traditional ways of working and enable greater digital literacy. It will build a system that focusses and measures outcomes and places less and less reliance on the site of care, moving to more accessible and personalised care. The strategy will reduce unwarranted variation in practice and outcomes, enhance specialisation and opportunities to improve research partnerships. The strategy will support prudent healthcare and improve the use of resources and maintain an affordable service that meets growth in demand. The Health Board is supporting the development of the strategy, with updates and the final implementation plan due by April 2020.	The clinical services plan will form a part of wider strategy development. Some elements will be developed in the annual plan for 2024/25 that is currently under development	The Clinical Services Strategy went through QSE Committee at the time. Since then discussed with EMD and AD of Transformation whose view is seeking to close this action as a clinical services strategy was developed and there have been various changes in leadership where the strategic context and approach has been reset since this action was taken in 2019	Nick Lyons, Executive Medical Director	Phil Meakin, Interim Board Secretary	Final Client approved	31/07/2020	01/12/2023	11

254	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Oversight and scrutiny of Divisions / IHCs	Review of all meetings attended across the three areas by the Risk Management Department is required. This will give a better understanding of what meetings are taking place as well as providing a more consistent and robust approach towards the Divisions/IHCs risk management arrangements. Clarification required on how the West IHC will provide assurance on its risk management arrangements without a IHC meetings Risk Management Group meeting taking place.	At the Risk Team Meeting, Regional Managers were asked to produce an excel spreadsheet of meetings which review and scrutinise risks for the rest of the year. Any cancellation of meetings and reasons why to be fed back during the Risk Team with repeat cancellation of meetings for escalation to the AD of Governance. Regional Manager West is working with West IHC to provide assurance on its risk management arrangements without the Risk Management Group meeting taking place. Meeting arranged with IHC Medical Director, Interim Head of Risk Management and Regional Manager West on the 1st June 2023 for further discussion and action (additional IA comments to the Management Response - Actions will need to be reviewed following the outcome of the meeting on 1st June 2023).	All meetings have been mapped by the team but this needs to be signed off by the Head of Risk Management before closing.	All meetings have been mapped by the team and signed off by the Head of Risk Management before closing. Additional evidence in the form of Risk Meeting tracker provided to support closure.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	30/08/2023	28/02/2024	3
256	PFIG	Internal Audit	Planned Care Recovery and Transformation Group	2023	Limited	High	Planned Care Recovery and Transformation Group	It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.	A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July. Programme resources have been identified and we are working to appoint individuals into lead roles.	Update required	Planned Care Programme established with agreed governance, meeting every 6 weeks. Copy of Programme Board TORs provided as additional evidence for closure	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/07/2023		0
258	QSE	Internal Audit	Data analysis – Triangulation of data	2023	Limited	High	Triangulation of Data sets using consistent naming conventions	The Deputy Director of Quality: Continues to support the Quality Lead Manager develop the use of all data quality sets to inform Health Board wide reporting – This should be a priority. Ensures the standardisation of 'Location' within Datix, reviews the data associated with 'Do Not Use' and removes duplication of 'Categories', ensuring an appropriate audit trail where these are amended. Considers and progresses the findings within Paragraphs 2.3 to 2.5 inclusive of the Detailed Findings.	Following on from the re-alignment of the quality functions, a new Quality Insight and Systems Team is being created. New standard operating procedures for quality systems such as Datix are being developed which will include standardisation of analysis, reporting and dashboards. Working with the national Once for Wales RLDatix Team, a new locations and services hierarchy was implemented in April 2023 which aligns to national standards under the Once for Wales RLDatix programme and best practice. A change control process will be in place via the SOPs mentioned above. The findings from internal audit will be reviewed with the respective quality governance teams and findings will be shared with the executive-chaired Quality Delivery Group.	Draft Dashboard will be in place for end of November 2023.	The new team is in place and all posts filled permanent or on internal secondment. A quality systems group is in place with representatives from key teams. The group provides central coordination of system development and approved all system changes. Meeting pack as of the Quality Systems Group provided as further evidence.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	31/08/2023	31/11/2023	1
260	QSE	Internal Audit	Data analysis – Triangulation of data	2023	Limited	High	Quality, Safety and Experience Committee reporting	The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes.	Following changes within the Board arising from Special Measures, the new members of the Committee are working with the Executive Director of Nursing and Midwifery (as executive lead for the QSE Committee) to revise the committee terms of reference and cycle of business. As a result, the reporting expectations and requirements will be revised. The special measures reviews of patient safety and quality governance systems by the Independent Special Advisors will also inform this work.	This action to remain open until after the December QSE meeting, that way we can provide the final cycle of business and minutes as evidence to support closure.	The QSE terms of reference and cycle of business, including standard reports as revised and approved by Board in January 2024.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	30/09/2023	31/12/2023	1
268	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Accountability meetings (a)	The Health Board continue with the improvement plan to review and update Performance and Accountability Framework, ensuring meetings are scheduled regularly and the information discussed in performance meetings is captured, with expected outcomes clearly communicated to senior managers.	Agreed – Interim Director of Performance working closely with Interim CEO to agree/consult on direction of travel. Underway and first draft anticipated Q2, 2023/24.	Integrated performance Reviews have been put in place and will be held between 18th December 2023 and 22nd January 2024.	Executive Delivery Integrated Performance Group now embedded within the HB, reporting throughout and external to HB completed. Additional evidence of Group TORs, action log and minutes provided to support closure.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/03/2024		0
273	QSE	Internal Audit	Hergest Unit Notice of Contravention (NoC) Action Plan	2023	Limited	High	Action Plan evidence	The action plan evidence is reviewed immediately and updated to demonstrate all actions are embedded both at Hergest, with wider assurance to the Health Board on practice across the Division	The Notice of Contravention (NoC) Group will continue until just after the revised Court hearing (postponed from 03.08.2023) and will take forward the findings of this internal audit to direct further work and provide further evidence, as well as ongoing monitoring arrangements and intervention where recovery actions are required. Post-hearing, the NoC Action Plan (and Group) will be transferred to the Special Measures NCCU Action Plan and associated leadership/assurance arrangements to ensure alignment with the inpatient quality and safety programme, the special measures programme and to ensure ongoing sustainability of the actions.	HSE NoC Action plan evidence has been expanded to provide additional MH&LD Divisional activity aligned to the three material HSE Breaches. This will be provided by Teams due to the size of the documents. In addition, a Divisional wide HSE NoC Audit has been completed with additional layers of governance, audit methodology and incorporating lessons learnt from previous HSE NoC audit activity to demonstrate the ongoing journey of improvement across all areas of patient care. The court hearing has been rescheduled to the 18th December 2023, after this time the division will be in a more informed position. The narrative contained in the response column remains accurate and will be updated after the court hearing.	The HSE NoC court hearing occurred on 18th December 2023. The outcome of the court case was a fine of £200,000 with £13,000 court costs. As agreed by Divisional, Corporate and Welsh Government the NoC Action plan has been transferred to the National Collaborative Commissioning Unit (NCCU) Action plan with the associated leadership, governance and assurance arrangements in place to ensure the Division continues on their improvement journey. The NCCU Inpatient Safety Delivery Group continue to meet fortnightly to progress the actions of the NCCU Action plan aligned to the eight recommendations made from the NCCU and NHS Executive Inpatient review undertaken during May 2023. A MH&LD Update report on progress of the action plan has been submitted through due Governance and submitted to the NCCU and NHS Executive, who are due to undertake a Follow Up Review during February 2024. The overall aim of the Follow Up Review will be to observe and evidence where improvements have been made and sustained and outstanding actions have been completed or are progressing towards completion. Action to be marked as complete	Iain Wilkie, Interim Director MHLd	Teresa Owen, Health Board Lead for MHLd and Welsh Language	Final Client approved	31/10/2023	31/01/2024	1

284	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.1)	Management to develop robust written control documents to support operational processes and strengthen governance arrangements.	Agree with recommendation. Management will develop robust written control documents to support operational processes and strengthen governance arrangements. Much of this will be incorporated into 1.2 Terms of Reference.	Update required	This action is completed. A terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group. Copy of action plan provided as additional evidence for closure	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	13/10/2023		0
285	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.2)	Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making.	Agree with recommendation. Management will establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making.	Update required	This action is completed. A terms of reference has been finalised and decision making is documented. Minutes from monthly meetings will be recorded and an action plan is in place. Copy of action plan provided as evidence	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	13/10/2023		0
287	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Progress Update Log	Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the Progress Update Log is currently being reviewed – management should consider the appropriateness and current utilisation of the Evidence field within the Update Log.	Agree with recommendation. Management will ensure that responsible officers and completion dates assigned to improvement actions are documented. Management will consider the appropriateness and current utilisation of the Evidence field within the Progress Update Log.	Update required	This action is completed. Completion dates and improvement actions are now monitored via the action plan for the group. Responsible officers have been identified for each action. The evidence field and update log are incorporated onto the action plan. Copy of action plan provided as evidence	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	13/10/2023		0
290	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Review/consultation by Health Board Inpatient Falls Steering group	Draft Policy out for consultation with Falls Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	30/11/2023		0
291	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Approval required by the Health Board Patient Safety Group	Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	30/11/2023		0
292	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on BetsiNet.	Out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. If approved by PSG, this action will then be completed.	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. Copy of policy provided as evidence to support closure.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	31/12/2023		0
294	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards;	Good practice examples shared pan BCUHB alongside ongoing peer review process.	How to guide shared across all IHC's. Evidence relating to Falls Programme provided to support closure.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	30/11/2023		0
295	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult Inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model.	Good practice examples shared pan BCUHB alongside ongoing peer review process.	Complete: How to guide with peer review process shared across all IHC's evidence of peer review process via metrics and IHC reporting template. How to guide developed for Agency worker shared with temporary staffing. In addition Accreditation team are delivering training to Student Nurses within both Universities regarding FBHMA and Patient Handling Risk Assessments. To date over 150 Students Nurses have completed training session. Evidence relating to Falls Programme provided to support closure.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	01/02/2024		0
301	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.	3.1d Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls. Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health and Safety team.	Safeguarding matrix included in updated policy (with Steering Group for consultation before going to BCUHB PSG for ratification on 30/11/23). Agencies provided with access to Falls training on NHS Wales e-learning site. Monthly monitoring in place for completions.	Following the HSE report, a process has been implemented where agencies are able to request accounts for learning@wales for their workers who are active in BCUHB to enable them to complete Falls modules on this platform. However, we do not on-board any workers, and have not since October, without some form of falls training having been completed via the Agency and we advocate once on-boarded they must completed the falls modules via learning@wales platform. Some agencies have reported a backlog in their workers receiving their login information and we are following this up with the team. Evidence to support closure provided.	Clair Tipton, Head of Digital Workforce and Resourcing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	01/12/2023		0
303	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1a The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.	4.1a The revised Health Board policy NU06 outlines the following process for Inpatient falls to support identification of themes, trends and learning as follows: - Hot debrief on the ward following the fall for immediate learning and mitigation; - All falls are reviewed daily by local quality teams; - All falls are subject to focused review contained within Datix system; - All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; - All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. - The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings. - Ongoing Monitoring will be via Patient Safety team.	Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to Betsinet. This action can be closed as copy of 'NU06-The Prevention and Management of Adult In-Patient Falls Policy - V5.0' provided as additional evidence.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	01/12/2023		0
306	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b Action 3 - The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 2023 and will be an ongoing programme of training and support across the Health Board.	Incident management training sessions have commenced face to face on the acute sites. Weekly dates are arranged up until end of March 2024 and include face to face and virtual sessions. Training advertised on Betsinet, Nursing newsletter and disseminated to governance leads.	Weekly dates are arranged up until end of March 2024 and include face to face and virtual sessions. Further dates will be commissioned. Training advertised on Betsinet, Nursing newsletter and disseminated to governance leads. Evidence of training posters provided to support closure	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	20/11/2023		0

308	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	Action 1 - The Health Board recognises the need to improve upon and modernise the governance arrangements and management of validity of data and cleansing the waiting list. Funding was recognised as being required to address and strengthen the governance and management of the waiting lists.	The Health Board has now implemented WPAS (Welsh Patient Administration System) which provides us with a validation dashboard so we no longer use spreadsheets to manage data. The Health Board was successful in a bid against national planned care recovery and sustainability fund to strengthen booking processes and develop an in-house validation capability. This includes ongoing tranche validation work with plans to have a dedicated substantive validation team in place by start of 2023-24 financial year. At that point, validation will transition to business-as-usual rather than a cohort or tranche activity. Tranche validation work is currently underway together with recruitment of a substantive validation team that we anticipate being in post by the start of the new financial year. This action remains in progress. A revision has been made to the implementation date and it is anticipated that this will be complete by 31/03/2024 and will be business as usual.	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/07/2022	31/03/2024	1
309	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application.	Action 2 - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG (Welsh Government) who have engaged on the initiative with a view to scaling up pan-BCU (Due by 30/09/2022). The proof of concept to digitize and automate elements of the validation process is underway as part of the funded business case to establish a validation team.	As per response to Action 1 (tracker ID 308). Tranche validation work will cease at the end of this financial year (March 2024) and move to business as usual through a substantive in-house validation team. This action remains in progress.	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/09/2022	31/03/2024	1
310	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	Action 3 - Service validation model will be reviewed and redesigned as a component part of implementation of the substantive validation team, as part of the shift to business-as-usual processes under Action 1.	This action remains in progress to business-as-usual processes under Action 1 (referred to as ID 308 in this tracker).	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023	31/03/2024	1
311	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm	Action 4 - The Health Board recognizes the critical importance of risk stratification for overdue patients to minimize risk of patient harm. With the discontinuation of manual P value assignment under previous COVID protocols as noted in Actions 4 and 5, risk stratification now follows standing Welsh RTT guidance. A project is underway as part of the Planned Care Programme (see Action 7) to automate risk stratification based on referrals exceeding defined waiting time thresholds for their RTT classification. Automatic alerts will be generated for booking teams to facilitate urgent clinical review, re-prioritization, and escalation if needed. This multi-pronged approach will significantly strengthen oversight and proactive management of risk associated with overdue patients. Regular reporting will occur through the Planned Care Programme governance noted previously.	P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/04/2022		0
312	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 5 - P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/05/2022		0
314	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 7 – The Health Board recognizes the importance of aligned standardized removal reasons across all sites for consistency, improved analysis, and reduced errors or inconsistencies. Significant progress has already been made through the system consolidation actions updated below. Implementation of a single centralized Welsh Patient Administration System (WPAS) instance has established consistent removal coding structures across all Health Board sites and user groups. The migration to a unified WPAS platform with standardized data structures has eliminated the need for interim data alignment. By virtue of progress under Action 8 (action ID 315 in this tracker), removal reasons are now consistent organization-wide. With WPAS system convergence complete, the Health Board now has a single integrated structure for patient administration, referrals, waiting list management, and removals management. Standard operation procedures will reflect the centralized data system. This will further consolidate the gains from technical system consolidation to support consistency in removal reason usage. Progress will be monitored through Informatics governance.	A formal Planned Care Programme has been established which reports into an Executive Chaired Programme Board and ultimately onward to Executive Team. This board oversees progress against identified work streams and associated developments of which validation, booking and referral is a key programme of work. Operational progress around performance and delivery against RTT targets is monitored through weekly corporate access meeting. The recommendation will remain open until the automated, sustainable process is fully implemented by March 2024.	A formal Planned Care Programme has been established which reports into an Executive Chaired Programme Board and ultimately onward to Executive Team. A copy of the TORs for this Programme is attached as additional evidence for closure.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022	30/06/2024	1
315	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 8 – The Health Board has completed the implementation of a single instance of WPAS which closes this action.	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	WPAS Standardisation lead	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	May 2022		0
316	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 9 – As per action 8 (ID 315 in this tracker) – completed and closed.	As per action 8 (ID 315 in this tracker) – completed and closed.	The Health Board has completed the implementation of a single instance of WPAS which closes this action.	WPAS Standardisation lead	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	July 2022		0

318	PFIG	Internal Audit	Decarbonisation	2023	Limited	High	Matter Arising 1: Governance Structure (Design), Monitoring & Reporting (Operation)	Ensure that the Health Board has suitable reporting systems in place to provide continuing assurance on the progress of the decarbonisation action plan.	As articulated in the findings of the report the Health Board has formed an appropriate governance framework. The six subgroups formed aligns to the national recommendations and reports into the DPB which will then report to PPPH and the Board receiving assurance from this sub-committee. There is an acceptance of the infancy in which this framework has been formed and we will need to ensure the sub-groups offer the appropriate level of assurance to the DPB. The Decarbonisation Programme Board will ensure a formal governance framework is defined and agreed through the Terms of Reference. In addition this will align to the overall organisational governance structure, with reporting to PPPH once re-convened.		The Health Board has reestablished the PPPH board and the Decarbonisation Programme Board will be producing regular update reports as per the recommendation. There is still internal discussions on the final governance and accountability structure, and therefore the full implementation of the subgroups have been slightly delayed. Evidence relating to the PPPH provided as evidence to support closure.	Russell Caldicott, Interim Executive Director of Finance and Programme Lead	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/05/2024		0
321	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	Lessons have been learned from the initial implementation of the Once for Wales Datix System whereby handlers of incidents were able to close incidents without completing all mandatory fields – this is being changed forcing completion of the mandatory fields.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure.	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	29/02/2024		0
322	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	The ability for incident managers to by-pass steps in the incidents process within the system has also been identified. This issue will be fed back into the national team for development and where this is identified, then education and training will be offered to services/individuals.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	29/02/2024		0
323	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	A regular audit has started and is ongoing providing services with information on where managers are not completing the process.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	Incidents that have been closed in the previous 24 hours are reviewed by the Patient Safety Team to identify any incomplete fields and if required are reopened with feedback back to the incident manager. Evidence to support closure provided - daily/weekly report identifying gaps. Also included is a copy of communication sent to individual responsible for closing, with incident moved back to 'awaiting closure'.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	29/02/2024		0
325	QSE	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	Management to review implemented learning to ensure effectiveness.	The Organisational Learning Forum was launched earlier this year whose purpose is to identify themes and mechanisms to enable learning to be embedded across the organisation. A new, digital repository of learning and cascade system will be developed. NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.	Not applicable - recommendation added to tracker following 12/01/2024 Audit Committee	The Organisational Learning Forum was launched in 2023. Copy of Organisational Learning Forum minutes from December 2023 provided as additional evidence for closure	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	Completed		0

AUDIT COMMITTEE

AUDIT TRACKER - OUTSTANDING OR INCOMPLETE UPDATES

ID	Committee	Internal Audit (IA)/ Wales Audit Office	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Update for 15/03/2024 Audit Committee	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	For closure consideration at 15/03/2024 Audit Committee?	OBS Comments for Audit Committee 15/03/2024
123	PFIG	Internal Audit	Procurement and Tendering	2021	Reasonable	Medium	E waiver system	Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met.	3.1 We will investigate the possibility of updating the eWaiver system (as part of the 365 redesign) to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended.	The Finance Department have been re-developing the waiver system and following a period of user testing and a soft launch in December 2023, the system went live in February 24. Key areas of improvement are system compliance with delegated limits contained within the Scheme of Reservation and Delegation (SoRD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary; and improved reporting.	Denise Roberts, Head of Capital, Tax and Business Support	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2022	31/12/2023	9	No	Needs evidence to support closure. Not provided by tracker closedown, therefore marked as still open.
289	PFIG	Internal Audit	GP Out of Hours	2023	Limited	High	Board Assurance	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.	Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team.	This action is ongoing and in process. Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review.	Rachael Page, Assistant Director of Primary Care	Adele Gittos, Interim Executive Director of Operations	Started	27/10/2023		0	No	Need revised implementation date. Action owner also queried.
313	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 6 – Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.	These figures are submitted to WG on a weekly basis and also discussed in the weekly access meetings. The validation exercise had concluded. Long waiting patients (named Extreme Waits) are monitored weekly through Corporate Access (following local IHC Access weekly meetings that inform Corporate Access) with weekly updates provided to Welsh Government. As well as this (the monitoring of Extreme waits) the health board also reviews weekly Treat in Turn and the reduction of long waits this being >104 week waits and new outpatient referrals >52 weeks. As part of data quality, the health board has a continuing cycle of validation, this consisting of a two phased approach (data, and two stage patient contact) that has both clinical and Welsh Government approval.	Site Directorate General Managers	Adele Gittos, Interim Executive Director of Operations	Started	31/03/2022		0	No	Needs evidence to support closure. Not provided by tracker closedown, therefore marked as still open.

## Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: February 2024

Document reference: 4065A2024

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

© Auditor General for Wales 2023. No liability is accepted by the Auditor General or staff of the Wales Audit Office in relation to any member, director, officer, or other employee in their individual capacity, or to any third party, in respect of this report.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at [infoofficer@audit.wales](mailto:infoofficer@audit.wales).

# Contents

## Audit Committee update

About this document	4
Accounts audit update	5
Performance audit update	7
Other relevant publications	9
Additional information	9

## About this document

- 1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board.
- 2 We also provide additional information on:
  - Other relevant examinations and studies published by the Audit General.
  - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events and resources are available on our [website](#).

## Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

### Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the Health Board's Accounts: planning for 2023-24	Russell Caldicott, Interim Executive Director of Finance	Ongoing dialogue and meetings held to follow up on matters identified in our joint post project learning in preparation of the 2023-24 draft accounts and subsequent audit. Completion of planning and risk assessment stages of audit of the 2023-24 draft accounts.	Audit planning and our risk assessment work is underway to inform our Detailed Audit Plan 2024.	April 2024
Charitable Funds: <ul style="list-style-type: none"> <li>• Planning</li> <li>• Audit of the Charitable Fund Financial Statements</li> </ul>	Russell Caldicott, Interim Executive Director of Finance	This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Audit work is substantially complete. Delay due to outstanding assurance over investment manager control environment.	March / April 2024

## Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

### Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All Wales thematic work on Unscheduled Care Arrangements: Phase 1 work on patient flow and discharge planning	Adele Gittoes, Interim Executive Director of Operations	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Clearance: Draft report issued in February 2024.	May 2024
All-Wales thematic on workforce planning arrangements	Jason Brannan, Deputy Director of Workforce & Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Clearance: Draft report issued in December 2023.	May 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow-on work on board effectiveness	Carol Shillabeer – Chief Executive Officer	This work will consider the progress the Health Board has made in addressing the concerns on board effectiveness identified in the Auditor General’s report in the public interest in February 2023.	Completed.	March 2024
Structured Assessment 2023	Carol Shillabeer – Chief Executive Officer	<p>Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work will review:</p> <ul style="list-style-type: none"> <li>• Corporate systems of assurance;</li> <li>• Corporate planning arrangements; and</li> <li>• Corporate financial planning, management, and performance arrangements.</li> </ul> <p>Please note that board effectiveness, which is normally part of our core structured assessment work, will be considered separately in the follow-on work that has been referenced above.</p> <p>In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on <b>financial savings / cost improvement plans</b>.</p>	<p>Clearance: Draft issued in February 2024.</p> <p>Fieldwork in progress.</p>	<p>May 2024 To be considered by the Board in March 2024</p> <p>May 2024.</p>

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
<b>Planned Care</b>	Adele Gittoes, Interim Executive Director of Operations	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Planning	To be confirmed

## Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided.

### Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<a href="#"><u>Corporate Joint Committees – commentary on their progress</u></a>	November 2023
<a href="#"><u>NHS Wales Workforce data briefing</u></a>	September 2023
<a href="#"><u>Approaches to achieving net Zero across the UK</u></a>	September 2023
<a href="#"><u>NHS Wales Finances Data Tool</u></a>	September 2023

## Additional information

- 7 There have been no consultations since our last update.



Audit Wales

1 Capital Quarter, Tyndall Street,  
Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: [info@audit.wales](mailto:info@audit.wales)

Website: [www.audit.wales](http://www.audit.wales)

We welcome correspondence and  
telephone calls in Welsh and English.  
Rydym yn croesawu gohebiaeth a  
galwadau ffôn yn Gymraeg a Saesneg.



<b>Teitl adroddiad:</b> <i>Report title:</i>	Audit Wales Board Effectiveness Follow up Report and Health Board Response			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Friday, 15 March 2024			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The purpose of this report is to provide Audit Committee with: the Audit Wales report on the follow-up review of board effectiveness report and to provide the Health Board's response to the report's findings and recommendations.			
<b>Argymhellion:</b> <i>Recommendations:</i>	Audit Committee as asked to note the report and response			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Phil Meakin, Acting Board Secretary			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Nesta Collingridge, Head of Risk Management			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small> <i>No confidence / evidence in delivery</i>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	It is essential that the Health Board has robust arrangements in place to meet the requirements of legislation and the Standing Orders and Public Audit (Wales) Act 2004 and Government of Wales Act 1998 The report has been prepared for presentation to the Senedd under these Acts.			

<b>Goblygiadau rheoleiddio a lleol:</b>	As above
<b>Regulatory and legal implications:</b>	
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>	N/A
<i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>	N/A
<i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>	Strategic Priority P16 Board leadership and governance Board Assurance Framework Risk and Corporate Risk CRR24-16 Leadership/Special Measures
<i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i>	
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>	Failure to comply with the recommendations risks could have financial implications for the Health Board in terms of efficiencies and any non-compliance penalties.
<i>Financial implications as a result of implementing the recommendations</i>	
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>	Failure to comply with the recommendations risks perpetuating workforce instability, high leadership costs, weak financial governance, and potential service delivery inefficiencies
<i>Workforce implications as a result of implementing the recommendations</i>	
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>	A draft copy of the response was shared with members of the Executive Team before formal response back to Audit Wales.
<i>Feedback, response, and follow up summary following consultation</i>	
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	Strategic Priority P16 Board leadership and governance Board Assurance Framework Risk and Corporate Risk CRR24-16 Leadership/Special Measures
<i>Links to BAF risks: (or links to the Corporate Risk Register)</i>	
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>	Amherthnasol
<i>Reason for submission of report to confidential board (where relevant)</i>	Not applicable
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b>	
<i>Next Steps:</i> Implementation of recommendations outlined in the Health Boards response action plan	
<b>Rhestr o Atodiadau:</b>	
<i>List of Appendices:</i>	

## **1. Background**

In February 2023, the Auditor General published a report highlighting significant concerns about the effectiveness of the BCUHB board and wider senior leadership.

This prompted the Health Board being escalated to special measures status and the resignation of all independent members at the time.

## **2. Introduction**

### **Board Effectiveness follow-up report (Appendix 1)**

Audit Wales has now conducted a follow-up review approximately 12 months later to assess progress made in addressing the previous concerns.

The follow-up report finds that the previous dysfunctionality within the board is no longer evident, with more positive senior leadership and working relationships.

However, fundamental challenges remain, particularly around stabilising board and executive membership, improving corporate governance, developing a cohesive board/executive team, and rebuilding internal capacity.

Audit Wales outlines a number of priority areas for focus by the new leadership to drive necessary improvements.

### **Health Board Response (Appendix 2)**

In the response the Health Board accepts the findings of the Audit Wales report.

An action plan is provided outlining how the recommendations will be addressed through recruitment, board/executive development, organisational structure reviews and capacity building.

See Appendix 1 Report and Appendix 2 Response.

# Board Effectiveness Follow-up – Betsi Cadwaladr University Health Board

Audit year: 2023

Date issued: February 2024

Document reference: 3766A2023

This report has been prepared for presentation to the Senedd under the Public Audit (Wales) Act 2004 and the Government of Wales Act 1998.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at [infoofficer@audit.wales](mailto:infoofficer@audit.wales).

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.

# Contents

Summary report	
Background	4
Key findings	5
Detailed report	
Responding to independent reviews and investigations	6
Rebuilding and strengthening senior leadership capacity	9
Building a more cohesive and effective board and executive team	11
Concluding comments and on-going issues that need to be managed	14
Appendix 1 – Audit methods	16

# Summary report

## Background

- 1 In February 2023 the Auditor General for Wales published a report in the public interest on the effectiveness of the board at Betsi Cadwaladr University Health Board. The report described a worrying degree of dysfunctionality within the board and wider senior leadership of the organisation. The Auditor General concluded that collectively the concerns identified were fundamentally compromising the ability of the board to work effectively and in an integrated manner to address the significant challenges the Health Board faces. He also concluded that the situation was unlikely to be rectified without some form of external intervention.
- 2 The Auditor General's report highlighted:
  - clear and deep-seated factions within the Executive Team and, to an extent, the wider board;
  - concerns about Executive Team's grip on operational challenges and quality of assurances that were being provided to the board and its committees;
  - an erosion of trust and confidence that the Independent Members had in the Executive Team;
  - examples of very challenging public scrutiny of the executive by some Independent Members which adversely affected working relationships and functionality within the board;
  - a need to respond to and resolve the issues identified in a large number of whistleblowing disclosures that related to business processes and the behaviour of some of the then senior leaders of the Health Board;
  - a failure of previous board development work to secure more collegiate and unitary working within the board; and
  - pace of change and sustained improvement being affected by turnover, portfolio changes and a continued over-reliance on interim roles to cover key posts in the management structure.

The Auditor General's report on board effectiveness set out a number of areas for immediate action to resolve some of the key issues highlighted.
- 3 The week following the publication of the Auditor General's report on board effectiveness saw the Health Board placed back in special measures, and the resignation of all the board's Independent Members. Some 12 months on from these developments, this report sets out the findings of follow up work undertaken by the Auditor General. Recognising that the make-up of the board has fundamentally changed, our follow up work seeks to provide an up-to-date commentary on the effectiveness of the current board and the extent to which the areas for immediate action identified in our original report have been addressed. The fieldwork that informs the findings in this report was undertaken between late October and early December 2023.

## Key findings

- 4 Overall, we found that **following a period of significant disruption and churn during 2023, the board is now in a more stable position. There is a new substantive Chief Executive in post, the dysfunctionality within the board described in our previous report is no longer evident and working relationships amongst senior leaders are more positive in overall terms.**
- 5 **However, some fundamental challenges still remain in the context of an organisation that is in special measures. Substantive appointments to the board need to be completed as quickly as possible to bring the board up to full capacity. Work must continue to build a united and effective Executive Team, to resolve the on-going personnel issues in the Finance Department, and to strengthen corporate governance leadership arrangements within the organisation. These activities need to be supported by continued progress with a board development programme that builds a cohesive and unified board that supports a positive organisational culture by setting the right “tone from the top”.**
- 6 The findings underpinning these overall messages are summarised below under the following headings which align to the areas for immediate action identified in our February 2023 report:
  - responding to independent reviews and investigations;
  - rebuilding and strengthening senior leadership capacity; and
  - building a more cohesive and effective board and executive team.
- 7 Our concluding comments at the end of the report highlight the immediate priorities and on-going risks that the Health Board needs to manage as it moves forward.

# Detailed report

## Responding to independent reviews and investigations

- 8 Our review considered the extent that the Health Board effectively responded to findings of independent reviews and investigations. We considered whether the Health Board:
- adopted a pragmatic and effective approach to respond to the findings of the reviews of protected disclosures (whistleblowing);
  - responded effectively to the specific issues which affected the accounts opinion in 2021-22 and which led to the subsequent EY review and the qualified opinion in 2022-23; and
  - responded effectively to reviews undertaken as part of special measures, where the findings relate to board effectiveness (as part of this we considered the extent of board oversight of the Health Board's response to the reviews).
- 9 We found that **whilst the Health Board has made progress in responding to independent reports and recommendations, for a variety of reasons this has been slower than intended and there is scope to strengthen oversight in some areas.**

### Reviews of protected disclosures

- 10 As reported in our original review, during November and December 2022 a significant number of disclosures emanated from within the Health Board raising various concerns about business processes and the behaviour of some senior leaders within the organisation. In response, the Welsh Government commissioned independent reviews to investigate the concerns. These have been concluded and the findings considered by both the Welsh Government (in respect of concerns raised about previous Independent Members) and the Health Board (in respect of concerns raised about previous members of the Executive Team and other senior officers). Debrief sessions have been held with each of the current Executive Directors to share the findings from the reviews, and feedback provided to those who made the disclosures where their identity is known.
- 11 The issues identified by the independent reviews have partly been addressed through numerous changes to board membership in relation to both Independent Members and members of the Executive Team. Additional reviews undertaken as part of the escalation to special measures have also prompted improvements in specific areas, including processes for appointing interim senior staff on high-cost agency rates, as well as feeding into development programmes for the board and the Executive Team.
- 12 The above actions should enable the Health Board to move forward on the specific issues raised within the disclosures in 2022. However, in our view there is also a

need for the new board to set aside time as part of its board development to properly consider and reflect upon the findings from the independent reviews, and to ensure that lessons are learnt to help prevent similar circumstances occurring again. This should be part of the work that the board has already instigated on culture and compassionate leadership.

## **Responses to issues identified by the audits of accounts and EY**

- 13 The Health Board is responding to the issues identified in our audits of the 2021-22 and 2022-23 accounts, as well as those identified in the EY review. The issues highlighted included errors within accounts and a need for better training and strengthened financial controls, particularly in relation to contract management. Progress in addressing these issues has been slower than intended, although the Health Board has asked its Internal Audit service to undertake a review of procurement and contract management, the findings from which were being finalised at the time of writing this report. There is also scope for the board's committees to receive fuller information on these matters to aid oversight and provide assurance that all required improvements are addressed. Three senior members of the Health Board's Finance team remain suspended pending conclusion of the internal investigations that followed the EY review. The impact of this on the Finance Team is considered in a separate section later in this report.

## **Response to special measures**

- 14 The Health Board was placed back into special measures in February 2023. The Welsh Government's special measures framework was presented to the new board at the end of March 2023. The framework is based around a number of themes, starting with "discovery", and moving to "stabilisation" which would conclude at the end of February 2024, and then beyond that into phases of "standardisation" and ultimately "sustainability". As part of the discovery phase, the special measures framework incorporates independent reviews and other work in the following areas:
- Mental Health Inpatient Safety
  - Executive Portfolios
  - Use and recruitment of 'Interim' Staff
  - Planning
  - Patient Safety
  - Clinical Governance systems
  - Stocktake review of progress against previous Mental Health Reviews
  - Review of Office of the Board Secretary
  - Vascular review.
- 15 Although the board received the Welsh Government's framework in March 2023, at the time of the appointment of a new interim Chief Executive in May 2023, no special measures response plan was in place. This delay was due to uncertainties

in leadership arrangements at the time of escalation, especially regarding Accountable Officer responsibilities, as the previous interim Chief Executive was on sick leave. Once the new interim Chief Executive was in place the situation was quickly rectified with a special measures response plan in place by the end of May 2023. The plan is organised into three 90-day cycles from June 2023 through to the end of February 2024, and contains five clear outcomes including a well-functioning board.

- 16 The Health Board has assigned responsibility for operational oversight of delivery of the special measures response plan to the Executive Team and the Programme Management Office, and there is regular reporting to the board and its committees. The Health Board has grouped its actions and responses to the special measures plan and the individual reviews undertaken as part of the special measures framework under a number of themes<sup>1</sup>. This thematic analysis is helpful and necessary. However, it is important the Health Board also monitors and reports on the progress being made in addressing the more specific actions identified within individual reviews to prevent the risk of key actions being lost when consolidated into broader improvement themes.
- 17 The Health Board also needs to have a clearer way of describing progress within the special measures update papers provided to the board and committees. Narrative on progress prepared by Programme Management Office needs to be better aligned with the overall RAG rating provided by the Executive Lead. As part of this, the Health Board needs to ensure common understanding of its RAG rating process to avoid giving the impression that outcomes have been achieved when in practice there is still much work to be done.
- 18 Whilst good overall progress has been made in delivering actions set out in the special measure response plan, there has also been some slippage. This reflects some over-ambition on the part of the Health Board in setting the original milestones (in the context of an organisation looking to stabilise itself), and some delays in receiving a number of reviews that were commissioned as part of the discovery phase of special measures.

## Rebuilding and strengthening senior leadership capacity

- 19 Our work examined the actions that have been taken to rebuild and strengthen senior leadership capacity within the Health Board with a particular focus on:
  - the timely recruitment of a substantive Chief Executive Officer;

<sup>1</sup> There are seven themes within the special measures response plan, namely: Data, intelligence and insight; Culture; Risk Management; Patient, Family, Carer Involvement; Operating model; Organisation Governance and compliance; and Integrated planning.

- the action taken to reduce reliance on interim appointments in senior roles; and
- a need to bolster senior staff capacity within the Finance team to ensure business continuity.

20 We found that **important progress has been made in stabilising the Health Board’s senior leadership arrangements via the recruitment of a substantive Chief Executive. Progress has also been made in reducing reliance on interim arrangements to fill senior roles, although further work is still needed in this space. This is particularly the case in the Finance Team which has been significantly disrupted following the continued suspension of three senior members of that team. The Health Board also needs to move quickly to strengthen the leadership of its corporate governance arrangements.**

### **Recruitment of a substantive Chief Executive**

21 The Health Board’s initial attempts to recruit a substantive Chief Executive earlier in 2023 were not successful and a new interim Chief Executive was appointed in May 2023. In November 2023, the Health Board announced that the interim post holder had been successful in securing the substantive Chief Executive role following an open recruitment process, with the role commencing in early January 2024. This is a key step forward for the Health Board which should help stabilise organisational leadership, particularly in respect of the Executive Team. The fact that the substantive Chief Executive has already had a period in post in an interim capacity will assist with continuity and means that the post holder will have already built up an understanding of the specific issues and challenges facing the Health Board.

### **Reducing reliance on interim appointments to senior roles**

- 22 Our follow-up work found that the Health Board has made progress in reducing its reliance on interim roles in response to concerns raised in our previous audit work and the special measures review on use of interim managers.
- 23 Controls around the use of senior interim appointments have been strengthened, with evidence of better governance of establishment control and proper impact assessment for all requests to extend the tenure of senior interim roles. There is also evidence of better oversight of the use of interim roles by the Remuneration Committee. In addition, several people in interim roles who were paid on an agency rate basis have been moved to temporary NHS contracts which should help secure better value for money.
- 24 These are positive and necessary developments. However, some caution is needed when interpreting quoted reductions in the use of interim staff as there has been some re-classification of interims into “acting” roles. While it is technically accurate to refer to such staff in this way, it does not reduce the reliance on temporary staffing solutions. It is acknowledged, however, that in taking forward

longer-term plans to reduce reliance on interim roles, the Health Board will need adopt a managed approach to avoid de-stabilising key functions.

- 25 More broadly, the general direction of travel in respect of having less reliance on interim arrangements to cover senior leadership roles needs to continue. At the time of our fieldwork the role of Executive Director of Therapies and Health Sciences, the Executive Director of Workforce, the Executive Director of Operations, the Executive Director of Finance, and the Board Secretary were all being covered by interim or acting up arrangements.
- 26 The need to move away from having interim Board Secretary arrangements and recruit a substantive Director of Governance is a particular priority for the Health Board noting the immediate challenges that exist around the rebuilding of the board and some of the key governance arrangements that underpin it, including the reinstatement of a full committee structure below the board. We noted that at the time of our fieldwork the Health Board was running a recruitment campaign for a substantive Director of Corporate Governance.

### **Capacity of the finance team**

- 27 The ongoing investigations into the financial irregularities identified by Audit Wales and the EY review have inevitably had a disruptive effect on the finance team and have resulted in a reliance on interim appointments and temporary staffing arrangements. There has been churn in the team leadership with two interim Executive Directors of Finance and a need to support interim and temporary staff to get up to speed quickly. Staff resource has been moved into the team from elsewhere in the Health Board, but this has left resultant gaps in the roles they moved from which have needed to be filled.
- 28 The investigations in respect of the suspended staff have proved to be complicated processes and are still on-going some 12 months after the staff were originally suspended. A number of policies relating to Respect and Resolution<sup>2</sup>, Raising Concerns and Disciplinary Processes have needed to be activated which have collectively contributed to the elongated timescales. We understand that the Health Board is progressing the disciplinary investigations where it can, and that a further extension to the interim Executive Director of Finance's contract has been secured to the end of June 2024 to cover the completion of the 2023-24 accounts.

## **Building a more cohesive and effective board and executive team**

- 29 Our work considered the risks, challenges and progress made in relation to the operation of the Board and its committees since we published the Board

<sup>2</sup> Respect and Resolution processes seek to secure constructive and lasting solutions to workplace disagreements, conflicts and complaints.

Effectiveness review in February 2023, as well as the extent to which the issues we previously identified in relation to the executive team are being addressed. In examining these areas, we considered whether:

- the Health Board is taking action to ensure Independent Member capacity is sufficient to adequately discharge the board's functions;
- the quality of assurance provided to the board and its committees is improving and the scrutiny provided by Independent Members is appropriate and improvement-focussed and based on an agreed position on organisational risk;
- the Executive Team is functioning in a more cohesive and effective manner;
- progress has been made in building positive working relationships between new Independent Members and the Executive Team; and
- board development work has been undertaken to help support the concept of a cohesive and unitary board.

30 We found that **from a difficult position in February, the board and committee arrangements have steadily improved although there is much more to do which includes re-establishing a full set of committees below the board and improving the quality of assurances provided in board and committee papers. The factions we observed in the Executive Team during our original review are much less evident. This provides a basis for the further work required to build a cohesive Executive Team that is united around a common purpose and appropriately connected to other operational leadership structures in the Health Board.**

## **Rebuilding Independent Member capacity**

31 At the end of February 2023, the Chair, Vice Chair, and all the board's Independent Members agreed to step aside following the escalation to special measures. The Minister made a number of immediate direct appointments in the form of a new interim Chair along with three other temporary Independent Members.

32 The immediate departure of the whole cadre of the board's Independent Members inevitably created a significant degree of instability within the board and left it having to operate with an absolute minimum of Independent Members that were new to the organisation, and no Vice Chair. Action has been taken throughout the remainder of 2023 to slowly rebuild Independent Member capacity on the board. Recent substantive Independent Member appointments have included that of a Vice Chair and there are on-going processes to move from temporary to substantive appointments, including that of the Chair.

33 There was little or no induction for the directly appointed temporary Independent Members when they first took up their posts. This made an already difficult task even more challenging especially as not all of the appointees had an NHS background and had to quickly get to grips with a complex organisation in a state of significant disruption, facing a number of specific challenges and concerns about

the quality of several of its services. We understand that the Health Board has since moved to strengthen the arrangements for induction of new Independent Members.

- 34 Having to operate with a significantly reduced number of Independent Members has had a clear impact on the operation of the board's committees. The Partnerships People and Population Health (PPPH) and Mental Health and Capacity Compliance (MHCC) committees were stood down and their business subsumed into that of the remaining committees and the board. While our analysis found the has board continued to discharge its statutory requirements, the consequence of having fewer Independent Members has been less committee oversight and scrutiny on important business aspects such as planning, population health, workforce issues and aspects of mental health services. At the time of preparing this report the PPPH and MHCC committees were still stood down. We understand that once Independent Member recruitment is complete and the board is at full complement, the Health Board will implement a revised committee structure, which the board agreed in September 2023.
- 35 In the context of the challenges described above and the scale of the change within the board that took place in late February 2023, it is important to acknowledge the role that the interim Chair and the directly appointed Independent Members played in maintaining the core business of the board.

### **Quality of scrutiny and assurance**

- 36 Our February 2023 report highlighted concerns around the quality of the assurances provided to the board and its committees by officers. Our follow up work has seen some improvement but also a recognition by the Health Board that this is still an area for attention which will need to be a key priority for the new Director of Corporate Governance, working with all board members. In particular, some papers submitted to the board and its committees are too long and need to present a clearer and more concise picture of the issue in question, what is being done about the issue, what impact actions are having and what are the risks to improvement.
- 37 We previously reported that an important development for the Health Board will be ensuring that the Executive Team has the necessary ownership and oversight of the assurances that are provided to the board and its committees. This will include ensuring that the right officers attend to present items and that they are fully briefed on the topic being discussed. We have observed occasional recent examples where this has not been the case.
- 38 Our February 2023 report also drew attention to examples of overly robust and adversarial scrutiny of some officers by some Independent Members that was affecting the board's functionality and its ability to work in a cohesive and collective manner. It is positive to note that such behaviours are no longer present and that the style of scrutiny by the current Independent Members is creating a "safer space" to encourage a more open debate at board and committee meetings. The

move from virtual to face to face meetings has also been a factor in helping to build more positive working relationships within the board, as has work within the new board to develop an agreed approach to risk appetite and tolerance, supported by a clearer focus on standards.

- 39 The more positive environment that is now evident within the board and its committees should allow the new Independent Members to continue to develop in their role and to challenge appropriately but constructively when they need to. An important part of this is to ensure they quickly build up a good understanding of the Health Board's risks and challenges, noting that a lot of "corporate memory" was lost as a result of all the previous Independent Members standing down at the same time.
- 40 Particular challenges have been evident in ensuring adequate assurance, oversight and triangulation of information within the Quality, Safety and Experience Committee. This reflects the large volume of issues this Committee has to cover, the quality of assurances, and the fact that the Health Board is looking to replace "walkarounds" by individual Independent Members with "service visits" by all members of the board to learn more about how specific services are running.

## **Board development**

- 41 With the immediate challenges of stabilising the organisation and rebuilding Independent Member capacity, it is perhaps not surprising that our follow up work noted limited progress in implementing a programme of board development activity that focuses on the development of the board as a "unitary team". However, the board has held several development sessions which have included discussions on the role of a unitary board and on risk management. A forward programme of board development activity was being prepared at the time of our fieldwork. This will need to be informed by an analysis of the skills and experiences across the new Independent Member cadre and linked to any wider work that is considering the make-up of the board's committees.

## **Cohesiveness of the Executive Team and wider senior leadership arrangements**

- 42 There have been changes to the Executive Team make-up since our original review and the factionalised working relationships we described in our previous work are much less evident. We understand that Executive Team meetings are more effective with more constructive debate and better attendance.
- 43 However, there are still issues that need to be addressed, and which were contingent on the appointment of a substantive Chief Executive. These centre around responding to the review of executive portfolios undertaken as part of the special measures framework to ensure the executive team has the necessary breadth of skills and experience to meet the organisation's current and future challenges, moving away from long term reliance on interim roles, filling remaining

vacancies and having clear lines of accountability and responsibility within the team, linked to the Health Board's operating model.

- 44 Depending on the direction the new Chief Executive takes in response to the special measures review of executive portfolios, there may be a need to blend new roles such as a Director of Operations into the substantive team structure. The interim leadership arrangements that have operated since May 2023 have included the creation of an interim Executive Director of Operations post in August 2023. Our follow up work noted the need for greater clarity in respect of how the responsibilities for this post interface with others in the Executive Team. It will be important to reflect on these experiences as part of the onward development of the Executive Team.
- 45 There is also a need to consider how the Executive Team interfaces with the leadership roles that sit below it, most notably the Integrated Health Community (IHC) Directors but also with the leadership for its pan-North Wales services<sup>3</sup>. In particular, during the follow up review, it was apparent that there have been some tensions resulting from the IHC Directors feeling marginalised following changes to operational governance arrangements and decision-making processes, especially in respect of meeting the Health Board's financial challenges. We understand that these issues are being worked through constructively. As part of that, it will be important that the Health Board further develops a model of collective senior operational leadership that is understood and bought into, and which incorporates good clinical leadership and engagement within clearly defined accountabilities and responsibilities.

## Concluding comments and on-going issues that need to be managed

- 46 The concerns we set out in our February 2023 report on board effectiveness at Betsi Cadwaladr University Health Board were significant and extremely worrying. They described a degree of dysfunctionality within senior leadership arrangements hitherto unseen at the Health Board, or in any other NHS body in Wales.
- 47 It is therefore positive that this high-level follow-up report is able to conclude that the significant dysfunction we previously described is no longer present and that with refreshed senior leadership in place, the board has the opportunity to regenerate itself and lead the organisation through the challenges it continues to face.
- 48 However, significant challenges remain which will need energetic, focused, resilient and brave leadership to address. There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of

<sup>3</sup> The Health Board's Pan-North Wales services include Women's Services and Mental Health and Learning Disability Services.

the organisation. That includes getting to a position where the board has a full complement of substantive Executive Directors and Independent Members, and with a substantive Chair in place. Linked to this is the urgent need to re-establish a committee structure below the board that provides the necessary oversight, scrutiny, and support across all aspects of the organisation's business.

- 49 The raft of disclosures that were received towards the end of 2022 should be used to inform the programme of board development that the new board will need to put in place. In particular, it should inform the work that is underway on organisational culture and compassionate leadership, and ensure that this starts with the right 'tone from the top'.
- 50 A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance arrangements. The Executive Team must also be appropriately connected to the leadership structures that sit below it, something which will need to be supported by ensuring the Health Board's operational model is fit for purpose.
- 51 As the new board looks to take forward these challenges it will need to maintain a clear view on the outcomes it is seeking to achieve. Those must include rebuilding confidence in the Health Board's leadership within the organisation, and rebuilding trust and confidence in the Health Board amongst its external stakeholders.
- 52 In the short term, the Health Board will likely need to continue to draw upon appropriate levels of external advice and expertise as it responds to these challenges and the requirements of the special measures framework. However, it must also look to get itself as quickly as possible to a position where it has the necessary internal capacity and capability to sustain improvement and avoid the need to continually look to the outside for support to achieve the improvements which are necessary.

# Appendix 1

## Audit methods

The table below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from these methods.

Element of audit approach	Description
Observations	We observed board meetings as well as meetings of the following committees: <ul style="list-style-type: none"><li>• Board meeting on 28th September and 30th November 2023;</li><li>• Quality, Safety and Experience Committee 27th October 2023;</li><li>• Performance, Finance and Information Governance Committee 2nd November 2023; and</li><li>• Audit Committee, 16th November 2023</li></ul>
Interviews	We interviewed the following Senior Officers and Independent Members: <ul style="list-style-type: none"><li>• Dyfed Edwards (Interim Chairman);</li><li>• Gareth Williams (Vice Chair and Chair of Performance, Finance and Information Governance Committee); and</li><li>• Karen Balmer (Chair of Audit Committee)</li></ul>

Element of audit approach	Description
	<ul style="list-style-type: none"> <li>• Rhian Watcyn Jones (Chair of Quality, Safety and Experience Committee);</li> <li>• Dyfed Wyn Jones (Independent Member);</li> <li>• Mike Larvin (Independent Member);</li> <li>• Jane Wild (Associate Member);</li> <li>• Clare Budden (Independent Member);</li> <li>• Fon Roberts (Associate Member);</li> <li>• Carol Shillabeer (Chief Executive Officer);</li> <li>• Chris Stockport (Executive Director Transformation, Strategic Planning and Commissioning);</li> <li>• Gareth Evans (Acting executive Director of Therapies and Health Sciences);</li> <li>• Teresa Owen (Executive Director of Public Health);</li> <li>• Nick Lyons (Executive Medical Director);</li> <li>• Adele Gittoes (Interim Executive Director of Operations);</li> <li>• Angela Wood (Executive Director of Nursing and Midwifery);</li> <li>• Phil Meakin (Acting Board Secretary);</li> <li>• Russell Caldicott (Interim Director of Finance);</li> <li>• Jason Brannan (Acting Director of Workforce and OD);</li> <li>• Michelle Green (Integrated Healthcare Community Director East);</li> <li>• Libby Ryan Davies (Integrated Healthcare Community Director Central);</li> <li>• Ffion Johnstone (Integrated Healthcare Community Director West);</li> <li>• Ian Wilkie (Mental Health Director); and</li> <li>• Dylan Roberts (Director of Digital)</li> </ul>

Element of audit approach	Description
Documents	<p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none"> <li>• Special measures updates;</li> <li>• Board and committee papers;</li> <li>• Reviews undertaken as part of special measures first 90-day cycle;</li> <li>• Papers relating to use of interims;</li> <li>• Response to independent reviews;</li> <li>• Board development draft plans; and</li> <li>• Executive development draft plans.</li> </ul>





Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: [info@audit.wales](mailto:info@audit.wales)

Website: [www.audit.wales](http://www.audit.wales)

We welcome correspondence and telephone calls in Welsh and English.  
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Bloc 5, Llys Carlton, Parc Busnes Llanelwy,  
Llanelwy, LL17 0JG

-----  
Block 5, Carlton Court, St Asaph Business  
Park, St Asaph, LL17 0JG

David Thomas,  
Audit Director,  
Audit Wales

Sent by email - [Dave.Thomas@audit.wales](mailto:Dave.Thomas@audit.wales)  
**A hard copy will not follow**

**Ein cyf / Our ref:** CS/DT/CE24-0265

**☎:** 01745 448788 ext 6382

**Gofynnwch am / Ask for:** Emma Hughes

**E-bost / Email:** [emma.hughes19@wales.nhs.uk](mailto:emma.hughes19@wales.nhs.uk)

**Dyddiad / Date:** 26<sup>th</sup> February 2024

Dear Dave,

**RE: BCUHB Board Effectiveness Follow-Up Report**

Thank you for your work in reviewing and reporting on the effectiveness of the Board in your recent follow-up report

Please find below the Health Board's response to Audit Wales' *Board Effectiveness Follow up Betsi Cadwaladr University Health Board* at annex 1.

It is essential that the Health Board has robust arrangements in place to meet the requirements of legislation and the Standing Orders and therefore we welcome this report and want to thank Audit Wales for the findings and the recommendations. We agree fully that there is much more to do and it is encouraging to know that you have assessed the Board as more stable, with stronger leadership and engagement evident.

The full Board as well as the Audit Committee have seen and been involved in shaping the feedback to improve ownership and assurance on the required improvements.

Our focus now is on our forward plan to look to the future and have a real positive impact on our organisation, our staff and the people of North Wales.

Yours faithfully,

**Dyfed Edwards,**  
Cadeirydd/Chair

**Carol Shillabeer**  
Prif Weithredwr/Chief Executive

---

**Cyfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:**  
Swyddfa'r Gweithredwyr / Executives' Office  
Ysbyty Gwynedd, Penrhosgarnedd  
Bangor, Gwynedd LL57 2PW

**Gwefan:** [www.pbc.cymru.nhs.uk](http://www.pbc.cymru.nhs.uk) / **Web:** [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)

Mae Swyddfa'r Prif Weithredwr yn croesawu gohebiaeth yn Gymraeg a bydd yn sicrhau y darperir ymateb yn Gymraeg heb oedi.  
The Chief Executive's Office welcomes correspondence through the medium of Welsh and will ensure that a response is provided in Welsh without incurring a delay

## Annex 1 - Response to Audit Wales Review of Board Effectiveness

No.	Conclusion	Response
1.	<p>Significant challenges remain which will need energetic, focused, resilient and brave leadership to address. There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position where the board has a full complement of substantive Executive Directors and Independent Members, and with a substantive Chair in place. Linked to this is the urgent need to re-establish a committee structure below the board that provides the necessary oversight, scrutiny, and support across all aspects of the organisation's business.</p>	<p>A) Independent member recruitment is underway. it is anticipated that full recruitment could be achieved by March 2024.</p> <p>B) An Executive Director Recruitment Programme starts in earnest during Quarter 1 2024.</p> <p>C) The Committee structure will be fully established during Q4 of 2023/24. New Committees have completed their set-up meetings during January 2023, and development sessions are being planned for February and March 2024 in order to assist fully operational Committees for 2024/25.</p> <p>D) A focus on strengthening the approach to reporting(including standards of reports) will be undertaken in Q1 2024/25</p>
2.	<p>The raft of disclosures that were received towards the end of 2022 should be used to inform the programme of board development that the new board will need to put in place. In particular, it should inform the work that is underway on organisational culture and compassionate leadership, and ensure that this starts with the right "tone from the top".</p>	<p>A) The Board will be actively engaged in the Compassionate Leadership development following the Board Day with Michael west in Dec 2023.</p> <p>B) A Board 'Team-Development' approach will be determined during Quarter 1 of 2024/25 as new Board members join.</p> <p>C) The Chair and CEO will take personal leadership roles in steering organisational development through leading the people and Culture Committee (Chair) and the Organisational Development Steering Group (CEO).</p>
3.	<p>A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance arrangements. The Executive Team must also be appropriately connected to the</p>	<p>A) The Executive Portfolio Review, as well as other sources of evidence, have provide insight that shapes the form and function of the Executive Team. Quarter 4 will see a revised approach proposed and following engagement and any necessary modification, actively implemented including recruitment into vacant posts.</p> <p>B) The Director of Corporate Governance role has been recruited and a commencement date likely ahead of the new financial year. This appointment should provide leadership capacity and capability required to strengthen corporate governance across the organisation.</p>

	leadership structures that sit below it, something which will need to be supported by ensuring the Health Board's operational model is fit for purpose	C) A review of the Operating Model Structures is part of the Special Measures Response Plan, which will indicate where modification is required. Wider ways of working that connect the Executive with broader leadership will be further evaluated as part of this work.
4.	As the new board looks to take forward these challenges it will need to maintain a clear view on the outcomes it is seeking to achieve. Those must include rebuilding confidence in the Health Board's leadership within the organisation, and rebuilding trust and confidence in the Health Board amongst its external stakeholders	<p>A) An outcomes focused approach has been set within the Special measures Response Plan and as the planning for 2024/25 and beyond proceeds, outcomes will form a key element of objective setting, performance monitoring and assurance mechanisms.</p> <p>B) In addition to internal staff surveys that measure confidence in leadership and management, consideration will be given to mechanisms to gain external, stakeholder feedback ahead of 2024/25.</p>
5.	In the short term, the Health Board will likely need to continue to draw upon appropriate levels of external advice and expertise as it responds to these challenges and the requirements of the special measures framework. However, it must also look to get itself as quickly as possible to a position where it has the necessary internal capacity and capability to sustain improvement and avoid the need to continually look to the outside for support to achieve the improvements which are necessary.	A) As part of creating the Organisational Development Plan, a capacity and capability assessment will be undertaken, to reflect where specific expertise will be required. The implementation of the OD Plan will be incorporated into the 2024/27 3 Year Plan (IMTP).