Bundle Audit Committee 4 March 2025

1 09:30 - PRELIMINARY MATTERS

1.1 09:30 - AC25/28 Welcome and Apologies - Verbal (Chair)
Apologies from Dyfed Jones

1.2 09:31 - AC25/29 Declarations of Interest - Verbal (Chair)

1.3 09:33 - AC25/30 Unconfirmed Minutes of Meetings held on 16.01.25 - Attached (Chair)
AC25.30 Minutes from Audit Committee 16.01.25 V0.02 Unconfirmed (Public)

1.4 09:35 - AC25/31 Matters Arising and Action Log - Attached (Chair)
AC25.31 Summary Action Log Audit Committee (Updated 25.02.25) Public

2 09:45 - GOVERNANCE

2.1 09:45 - AC25/32 Information Governance and Records Management Position Update - Paper (Head of Information Governance)
Carol Johnson to join the meeting for this item
AC25.32 Information Governance and Records Management Update - Coversheet and Report - Final

2.2 10:00 - AC25/33 Risk Report & Corporate Risk Register - Paper (Head of Risk Management)
AC25.33 AC Risk Report and Corporate Risk Register February 2025

2.3 10:10 - AC25/34 Standing Orders Reservation and Delegation of Powers - Paper (Director of Corporate Governance)
AC25.34 Audit Committee - SORD Update
AC25.34.1 Standing Orders amended February 2025 - Appendix 1

2.4 10:20 - AC25/35 Audit Committee Terms of Reference - Paper (Director of Corporate Governance)
AC25.35 Audit Committee Terms of Reference

2.5 10:25 - AC25/36 Audit Committee End of Year Review - Verbal (Director of Corporate Governance)

3 10:35 - FINANCIAL FOCUS

3.1 10:35 - AC25/38 Conformance Report Q3 2024/25 - Paper (Executive Director of Finance)
AC25.38 Audit Committee - Conformance Report - Q3 2024-25 DRAFT V2

3.2 10:50 - BREAK

4 11:00 - INTERNAL AUDIT

4.1 11:00 - AC25/39 Internal Audit Progress Report - Paper (Head of Internal Audit)
AC25.39 IA progress report Cover Sheet March 2025
AC25.39.1 BCUHB Audit Committee progress report March 2025 (App 1)

4.2 11:20 - AC25/40 Internal Audit Plan 2025/26 and the Internal Audit Charter - Paper (Head of Internal Audit)
AC25.40.1 Draft BCU Internal Audit Plan 2025-26
AC25.40.2 BCU-2425-32 Final Internal Audit Report Job Evaluation

5 11:30 - EXTERNAL AUDIT

5.1 11:30 - AC25/41 External Audit Progress Report - Paper (Audit Manager, Audit Wales)
Item withdrawn - included in the next agenda

5.2 11:45 - AC25/42 Final Accounts Memorandum, Annual Audit Letter and Audit Plan 2025/26 - Paper (Audit Manager, Audit Wales)
AC25.42.1 Betsi Cadwaladr University Health Board Final Accounts Memo 2023-24
AC25.42.1 A - BCUHB Annual Audit Report 2024
AC25.42.1 B - Detailed Audit Plan 2025 BCUHB

6 12:05 - COUNTER FRAUD

6.1 12:05 - AC25/43 Local Counter Fraud Service Q3 Report 2024/25 - Paper (Executive Director of Finance)

AC25.43 PUBLIC -Counter Fraud Audit Committee Q3 Report 2024-2025

6.2 12:15 - AC25/44 Local Counter Fraud Service Workplan 2025/26 - Paper (Executive Director of Finance)

AC25.44 PUBLIC Appendix A – Annual Counter Fraud Workplan 2025-2026

6.3 12:25 - AC25/45 Local Counter Fraud, Bribery and Corruption Policy - Paper (Executive Director of Finance)

AC25.45 PUBLIC Appendix B – Revised F03 Counter Fraud, Bribery and Corruption Policy

7 12:35 - FOR INFORMATION

7.1 12:35 - AC25/46 Summary of Business to be Reported from Private - Paper (Head of Corporate Affairs)

AC25.46 Audit Committee (Summary of Business to be Reported from Private)

7.2 12:37 - AC25/47 Forward Workplan - Paper (Head of Corporate Affairs)

AC25.47 Workplan for Audit Committee (Live Version as at 25.02.25)

8 12:39 - CLOSING BUSINESS

8.1 12:39 - AC25/48 Agree Items for Referral to Board / Other Committees - Verbal (Chair)

8.2 12:41 - AC25/49 Review of Meeting Effectiveness - Verbal (Chair)

8.3 12:43 - AC25/50 Date of Next Meeting - 30.04.25

8.4 12:43 - Resolution to Exclude the Press and Public

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

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Audit Committee
held in Public on 16 January 2025
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Karen Balmer	Independent Member (Chair of Audit Committee)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member
In Attendance	
Russell Caldicott	Interim Executive Director of Finance
Pam Wenger	Director of Corporate Governance
Simon Cookson	Director of Audit and Assurance
Nicola Jones	Deputy Head of Internal Audit
Fflur Jones	Performance Audit Lead, Audit Wales
Michelle Phoenix	Financial Audit Manager, Audit Wales
Danielle Timmins	Head of Counter Fraud
Glesni Driver	Head of Covid-19 Inquiry and Thirlwall Inquiry
Carol Shillabeer	Chief Executive *(part meeting)*
Imran Devji	Interim Chief Operating Officer *(part meeting)*
Mike Parry	*(part meeting – via Teams)*
Gareth Evans	Central IHC Director *(part meeting – via Teams)*
Naomi Holder	Central IHC Director of Nursing *(part meeting – via Teams)*
Adam Mackridge	Strategic Lead for Community Pharmacy *(part meeting – via Teams)*
Chris Stockport	Executive Director of Transformation & Strategic Planning *(part meeting)*
Nicola Eatherington	Assistant Area Director *(part meeting)*
Sreeman Andole	Interim Executive Medical Director *(part meeting – via Teams)*
Nick Graham	Associate Director of Workforce Optimisation *(part meeting - via Teams)*
Matthew Joyes	Deputy Director for Legal Services *(part meeting – via Teams)*
Committee Support	
Philippa Peake Jones	Head of Corporate Affairs
Laura Jones	Project Support Manager (Corporate Governance)

PRELIMINARY MATTERS
AC25/01 Welcome and Apologies The Chair of the Committee welcomed everyone to the meeting and apologies were received for Urtha Felda and Dave Harries. The Chair extended well wishes to Dave Harries on behalf of the Committee.

AC25/02 Declarations of Interest

No declarations of interest were raised at the meeting.

AC25/03 Unconfirmed Minutes of Meetings held 05.11.24

In was resolved that the Committee:

- **AGREED** that the minutes of the meeting held on 05.11.24 were a true and accurate record.

AC25/04 Matters Arising and Action Log

There was discussion around the action log and the following was agreed:

- Actions that have the lead noted as Andrea Hughes should be transferred over to Denise Roberts.
- If there is a delay in completing an action within the timescales, an explanation should be included to state why there has been a delay and what action is being taken.
- Where documentation is circulated to members outside of the meeting in relation to an action, these actions should remain open until the Committee have agreed that the documentation provided either closes the action or further information is required.
- In relation to documentation circulated outside of the meeting, it was agreed to make this available via links included in the action log.

Internal Audit Progress Report

- There was discussion around action AC24/127.2 and it was agreed to keep the action open until the item focussing on EPRR Risks had been considered by the PPHP Committee at the meeting on 18.02.25.
- In relation to action AC24/127.4 and raising awareness of internal audit, it was confirmed that a video has been developed with input from Dave Harries and shared with the Chair. There is a need to introduce a communication plan across the organisation to understand how the audit plan will be developed. It was agreed to share the video with the Committee and provide an update at the next meeting in relation to the communication plan. Action AC24/127.4 on the action log to be updated to reflect this.

Trusted Assessor

- There was discussion around actions AC24/145.1 and AC24/101.13 relating to the role of the Trusted Assessor. It was agreed that further information is required, the current actions would be closed and a new action opened to hold a Board Development session focussing on the role of the Trusted Assessor.

Action:

- **AC25/04.1** Board Development Session focussing on the role of the Trusted Assessor to be arranged.

The Committee reviewed the action log and agreed to close the following actions:
AC24.99.8, AC24.99.9, AC24/145.1, AC24/145.2, AC24/146.1, AC24/147.1, AC24/147.3, AC24/147.4, AC24/147.5, AC24/154.1, AC24/154.3 & AC24.101.13.

These actions were approved for closure following consideration of the papers presented to the Committee: AC24.43.6, AC24.57.7.5, AC24.94.9, AC24/124.2, AC24/146.2, AC24/153.1, AC24/153.2 & AC24/154.4.

GOVERNANCE

AC25/05 Update on Outstanding Audit Recommendations

Members received the presentation and the Interim Chief Operating Officer highlighted:

- There has been a decrease in the number of limited assurance level open recommendations since September 2024.
- A number of key actions have been taken in relation to discharge arrangements including integrating processes and workstreams, with a plan to submit all outstanding audit actions for closure by the end of February 2025.
- Once the backlog has been cleared, the plan is to deal with any additional issues via the Operational Leadership Team and ensure systematic checks are in place.
- The IHC Leadership Team have been working on the volume of open complaints with support from Audit Wales.
- Following an internal audit review of historical recommendations relating to effective governance at Ysbyty Gwynedd, the recommendations have all been approved for closure.
- The discharge policy has been completed and presented to the Urgent and Emergency Care Improvement Programme Board which includes membership from partner organisations. Going forward this will allow close working with Local Authority colleagues to ensure an integrated approach is adopted.

In discussing the presentation, the Committee:

- Highlighted the length of time that some of the recommendations have been pending approval. It was confirmed that there has been a lack of traction in relation to historic audit recommendations and progress is being made to gain approval and provide assurance.
- Noted that the Local Authorities are beginning to move forward with partnership working.

The Central IHC Director and Central IHC Director of Nursing provided an update in relation to the Final Audit Report on Effective Governance (IHC Central) highlighting:

- The amount of work that has been completed to date by the team to deal with the recommendations, provide stability and ensure delivery of the actions.
- A number of areas required support to gain grip and control over the significant volume of open complaints. The initial focus was on volume rather than compliance to ensure processes and structures were in place.
- The live figure was confirmed as 72.5% of complaints closed which is close to the target of 75%.
- A high volume of complaints have been closed within a 30-day period which has increased the compliance rate and the team were thanked for their work.
- The team are now aware of the hot spots and are working to ensure robust, high-quality responses are being sent out to patients and families within the shortest time possible ensuring open lines of communication during that time.
- This will remain an area of focus, there is now an understanding of the themes and a reduction in the severity of complaints.

In discussing the update, the Committee:

- Acknowledged the improved position and congratulated the team on the work completed to reach this point.
- Queried whether the themes are comparable with the other IHCs and across the organisation to provide potential prevention. It was confirmed that the key themes are around access to services and surgery, patients understand there are long waits but request regular communication from the Health Board. Further work is required to assess harm to patients on extensive waiting lists and address clinical prioritisation.
- Referred to the item on the agenda relating to Learning from Events (LfERs) and queried what assurance could be provided that these issues are being addressed. It was confirmed that there has been a recent focus on Nationally Reportable Incidents (NRIs) which has resulted in a reduction in NRIs. There is a need to provide the same focus and scrutiny on LfERs and there are plans in place over the next six months to manage these following the same process.
- Noted that communication with patients is key to ensure they understand why they are waiting and how long this is likely to be.
- Suggested the learning from the Final Audit Report on Effective Governance (IHC Central) is shared with the other IHCs and pan BCU.

Action:

- **AC25/05.1** Learning from the Final Audit Report on Effective Governance (IHC Central) to be shared with the other IHCs and pan BCU.

It was resolved that the Committee:

- **RECEIVED** the presentation.
- **NOTED** the Central IHC formal complaints positional update.

AC25/06 Update on Open Audit Recommendations

Members received an update on the following audit reports to provide a level of assurance that responses and updates have been received by the Committee:

Audit Wales Community Pharmacy Data Matching Pilot

The Strategic Lead for Community Pharmacy highlighted:

- A letter from Welsh Government was received in September 2024 based on a pilot completed by Audit Wales reviewing possible opportunities for fraud within Health Boards across Wales.
- Some issues were identified by Audit Wales and responses from the Health Board were required for assurance that appropriate systems are in place to prevent losses. The paper highlights the need for additional checks relating to unnecessary / inappropriate prescribing and loss or fraud relating to expensive medicines.
- This is now being monitored with Medicines Management and Counter Fraud and a dashboard has been developed to support this work.

In discussing the update, the Committee:

- Suggested this is picked up as part of the Counter Fraud work to provide an additional level of assurance back to the Committee.

- Agreed this will be reviewed by the Head of Counter Fraud and an update will be provided as part of the Counter Fraud Progress Report.

Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub
The Executive Director of Transformation & Strategic Planning and the Assistant Area Director highlighted:

- Out of the 6 open recommendations, 2 remain open and 1 is expected to close over the coming days.
- Recommendation 8.1 relating to a review of the capital manual procedures is progressing but not completed to date.
- Recommendation 5.1 relating to the project bank account is due to close shortly.

In discussing the update, the Committee:

- Referred to recommendation 8.1 and suggested that virtual sign off could be introduced under the Standing Financial Instructions (SFIs) as the Scheme of Reservation and Delegation (SoRD) is currently being reviewed. This would need to be discussed further outside of the meeting to ensure compliance with the processes and governance ahead of being used for other capital programmes.
- Referred to recommendation 5.1 and discussed the issues relating to not having a project bank account. It was suggested that this could be a regulatory issue and a potential breach of the SFIs therefore there is a need to follow up the governance element of the lack of bank account and report back to the Audit Committee if this is a breach. Withholding payment to the contractor until the account is opened may be an option if necessary.

Final Internal Audit Report on Consultant Job Planning
The Interim Executive Medical Director and the Associate Director of Workforce Optimisation highlighted:

- The organisation has more than 1200 doctors and 834 of those employees require a level of job planning as this is a contractual agreement.
- The vision for the workforce plan is to reduce non contractual pay and address demand and capacity within the specialties.
- The underpinning issues have led to a lack of assurance in relation to the medical workforce having sufficient job plans in place.
- The aim is to implement a similar system to the current e-rostering system used for nursing staff.
- The report has identified a range of recommendations and monitoring and evaluation of progress against the action plan is due to start from March 2025.
- Work has commenced in relation to reviewing data quality to allow the system to capture the required information to provide assurance to the organisation.
- The team are aiming to have 90% of job plans completed by the end of the year and workstreams to address this have commenced.
- Discussions have taken place with the Joint Local Negotiating Committee (JLNC) and concerns have been raised regarding contractual obligations for employees. The JLNC will join the working group that is being developed and the draft policy is being revised to ensure progress can be made in terms of implementation.
- The aim is to improve efficiency and productivity and it was noted that this continues to be a difficult area to address across all Health Boards in Wales.

In discussing the update, the Committee:

- Suggested that the report is taken through the People & Culture Committee in terms of progress and oversight and returned to the Audit Committee with the findings early in the new financial year.
- Highlighted that this will form part of the value and sustainability work which includes areas such as rota management and temporary staff utilisation to provide a more structured approach.
- Undertook to alert the Board of the current position.

Actions:

- **AC25/05.1** Head of Counter Fraud to review the Audit Wales Community Pharmacy Data Matching Pilot and provide an update as part of the Counter Fraud Progress Report.
- **AC25/05.2** Review introducing virtual sign off for capital programmes under the SFIs as part of the review of the SORD.
- **AC25/05.3** Follow up the governance element of the lack of a project bank account, if it is considered to have been a breach of SFI's then report back to the Committee.
- **AC25/05.4** Progress and oversight of the Final Internal Audit Report on Consultant Job Planning to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.

It was resolved that the Committee:

- **NOTED** the response provided from the Health Board's Chief Pharmacist's Office and Local Counter Fraud Specialist in relation to the Audit Wales: Community Pharmacy Data Matching Pilot.
- **NOTED** the update on the Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub.
- **NOTED** the update on the Final Internal Audit Report on Consultant Job Planning.

AC25/07 Update Report on Internal and External Audit Recommendations

Members received the report and noted the progress made to date. In presenting the report, the Director of Corporate Governance and Head of Covid-19 and Thirlwall Inquiry highlighted:

- The team have recently been dealing with historic recommendations and are now in a position to address the process for managing current audit recommendations going forward.
- There is an aim to move from a manual to an electronic system in the near future.
- Officers are being brought into this space which provides assurance to the Committee in terms of dealing with limited assurance reports. It was recommended that the Executive Director of Nursing or Executive Director of Public Health are asked to present at the next meeting due to the level of limited assurance reports in these areas.
- Appendix 1 includes a summary of audit recommendations that are proposed for closure and these will be processed via the current procedure.
- Issues have been identified by internal audit that some evidence provided has not been robust enough to close recommendations therefore this will be an area of focus.

In discussing the update, the Committee:

- Commented on the number of recommendations that have to be returned due to insufficient evidence. It was suggested that a level of understanding is required in terms of the purpose of Internal Audit and the need to provide assurance to the Audit Committee in relation to the evidence provided.
- Highlighted the importance of keeping track of the limited assurance recommendations to ensure they progress.
- Queried access to the most recent data, it was confirmed that the process is a lengthy process due to the need to provide assurance around the closure approval of recommendations by the Executive and the Executive Team.

Action:

- **AC25/07.1** Invite the Executive Director of Nursing or Executive Director of Public Health to provide an update on their Internal and External Audit Recommendations at the next meeting.

It was resolved that the Committee:

- **NOTED** the current position with regards to open recommendations, those proposed for closure, and 'unsatisfactory' and 'limited' assurance recommendations.

AC25/08 Historical External Audit Recommendations

Members received the report and noted the progress made to date. In presenting the report, the Director of Corporate Governance and Head of Covid-19 and Thirlwall Inquiry highlighted:

- The team have been reviewing the historic recommendations referring to the Structured Assessment and gaining assurance via External Audit.
- Appendix 1 highlighted the pre 2022 audit recommendations and Audit Wales have supported the closure of these recommendations.
- In relation to the Board Effectiveness Review, there were some recommendations that were suggested for closure and it was confirmed that the remaining recommendations would be followed up as part of the Structured Assessment.
- Triangulation is required with the 2024 Structured Assessment to ensure any recommendations transferred are kept open and monitored.
- Going forward the team would be able to focus on more recent recommendations and the Head of Covid-19 and Thirlwall Inquiry was thanked for her rigour and hard work.

It was resolved that the Committee:

- **NOTED** the current position with regards to historical External Audit recommendations;
- **APPROVED** the proposals within the report relating to historical External Audit recommendations;
- **NOTED** the position in relation to the Board Effectiveness Review and Follow-up and **APPROVED** the closure of recommendations as the Audit Committee were satisfied with the assurances provided.

AC25/09 WRP Penalties - Learning from Events Report (LfER)

Members received the report and noted the progress to date. In presenting the report, the Deputy Director for Legal Services highlighted:

- A new process has been introduced by the Welsh Risk Pool (WRP) and there is a need for the team to ensure clear processes are put in place to provide assurance in this area.
- The WRP introduced penalties for late receipt of forms at the start of the last financial year, a total of 3 penalties were reported at the previous meeting and a further 25 penalties have now been received amounting to a total cost of £70,000.
- The summary of overdue LfERs currently totals 106 – this could lead to additional penalty charges and an increase from £70,000 to £265,000. The team are liaising with WRP to avoid this.
- The team are developing a new process for LfERs to try and simplify the process for use by services which includes clear responsibility, accountability and timescales at each stage of the process to ensure greater ownership from a higher level.
- The backlog position is an issue and each division are being asked to develop a recovery plan over the next six months. Once the backlog has been addressed, the teams will be able to manage LfERs in real time.

In discussing the update, the Committee:

- Queried how confident the team were in dealing with the backlog whilst addressing the current LfERs. It was confirmed that the central legal team have set specific targets which are due to be met however there are challenges within the services to address this.
- Requested to see a sample of an LfER to understand the issue, it was agreed that this would be done as part of a Board Development session.
- Suggested the need to ensure sustainable improvements and manage the information that is being reported within the local performance reports.
- Confirmed that the team are working closely with the WRP and support is being provided.
- Highlighted the potential financial risk in relation to the penalties and suggested this needs to be reported via the Integrated Performance Executive Delivery Group ensuring that the Audit Committee have oversight of those not responding to LfERs and incurring costs.

Actions:

- **AC25/09.1** Share an example of an LfERs with the Independent Members - this will be done as part of a Board Development session.
- **AC25/09.2** Report to the Integrated Performance Executive Delivery Group and ensure the Audit Committee have oversight of those not responding by providing updates via the Quarterly Conformance Report produced by the Finance Team.

It was resolved that the Committee:

- **NOTED** the report.

AC25/10 Update on Health Board Policies and Written Control Documents

Members received the report and noted the progress to date. In presenting the report, the Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry highlighted:

- The report has been developed following a request from the Committee to establish a process for reviewing policies and procedures.
- The team have highlighted the overdue policies reporting that there has been a reduction and the current figures stand at 57, these overdue policies will be the focus over the next six months.

- There is a need to review the process and develop a more streamlined approach going forward.

In discussing the report, the Committee:

- Queried whether the policies that carry the biggest risk could be summarised rather than those that are at risk of being overdue.
- Enquired whether policies or written control documents are being used more frequently by staff and which has the biggest impact. It was confirmed that the policies need to be clear to inform the written control documents.
- Confirmed the need for the team to focus on the priority areas and highlighted that the Policy Oversight Group is working to try and streamline the process.

Action:

- **AC25/10.1** Summarise the policies that carry the biggest risk and provide a paper to the Committee in April 2025.

It was resolved that the Committee:

- **NOTED** the position on all policies/WCDs due for review in quarter 2 of 2024/25, as at 2nd October 2024.
- **NOTED** the current status of all out-of-date policies and WCDs.
- **NOTED** the categorisation of risks around overdue policies and WCDs, and the progress being made to update these.
- **AGREED** the focus over the next 6 months should be on WCD assessed as 'high risk' and policies that are overdue as shown in Appendix 3.

AC25/11 Standards of Business Conduct Policy (OBS02 – Minor Changes)

In presenting the report the Director of Corporate Governance highlighted the changes included in the document and these were approved and endorsed.

It was resolved that the Committee:

- **SUPPORTED** the changes to the policy.

AC25/12 Board Assurance Framework

In presenting the report the Director of Corporate Governance highlighted:

- The Committee have been provided with the opportunity to comment on a previous version of the Board Assurance Framework (BAF) which has also been shared via the remaining Committees for comment.
- From April onwards, priority areas have been identified for delivery which can be mapped to the Annual Plan once this is approved by the Board.
- Relevant audit reports have been triangulated as part of this work to ensure impact against high level objectives.

In discussing the report, the Committee:

- Queried the assurance ratings on page 5 noted against the red rating and suggested that this is simplified to ensure people are aware that red highlights insufficient reliable evidence.

- Questioned the use of the phrase "risk of" on page 6 suggesting the principal risks may become clearer if the wording is revised.
- Highlighted gaps in controls relating to the Estates Strategy, it was confirmed that this would be addressed to include any additional controls required.
- Agreed the need to develop and simplify the language used as an Executive Team.
- Noted that in some cases the relevant responsible Committee had not been noted in the tables.
- Commended the progress made.

Action:

- **AC25/11.1** Amend the wording to show Red = Negative assurance: the Committee is satisfied that there is insufficient reliable evidence. Refine the use of the word risk under the principal risks (use more simple language)

It was resolved that the Committee:

- **RECEIVED** and **COMMENTED** on the contents of the BAF prior to consideration by the Board in January 2025.

AC25/13 Annual Report 2024/25 Arrangements

In presenting the report the Director of Corporate Governance highlighted:

- A discussion around the Annual Accounts has taken place in terms of timescales and a plan in now in place.
- The aim is to have a draft by 31st March which is then subject to Audit Committee sign off.
- A debrief session following last year has taken place to address the lessons learnt and provide some recommendations going forward.
- It was requested that the June Audit Committee is moved.

Action:

- **AC25/13.1** Change the date of the Audit Committee from 25/06/25 to 24/06/25 (preferably morning)

It was resolved that the Committee:

- **CONSIDERED** the arrangements that have been developed for the production of the Annual Report for 2024/25.
- **RECEIVED ASSURANCE** on the arrangements for the production of the Annual Report for 2024/25.

INTERNAL AUDIT

AC25/14 Internal Audit Progress Report

Members received the report and noted the progress in relation to Internal Audit. In presenting the report, the Deputy Head of Internal Audit highlighted:

- The difficulties faced by the team in accessing the required information and evidence for some of the reviews which affects the ability to test the integrity of the data and provide a full response.
- Four assurance reviews have been issued as final with three reasonable and one unsatisfactory.

- The Charitable Funds review has been rated as reasonable which is an improvement however there was one limited assurance rating relating to the recording of restricted and unrestricted expenditure.
- The Intelligence Led Organisation review has been rated as reasonable however issues have been highlighted in relation to data quality.
- The Special Measure review has been rated as reasonable however further work is required in relation to business continuity.
- Changes are required to the Internal Audit Plan; a revised version will go to the Executive Team in January 25 and back to the Committee in March 25.

In discussing the report, the Committee:

- Agreed to discuss the ongoing issue of providing unrestricted access to data for testing.
- Highlighted an issue in relation to restricted and unrestricted funds relating to the Charitable Funds review.
- Noted that the Committee had not received a copy of the Internal Audit Report on Charitable Funds.

Actions:

- **AC25/14.1** Russell Caldicott and Simon Cookson to discuss gaining unrestricted access to data outside of the meeting.
- **AC25/14.2** Share full copies of all Internal Audit Reports going forward.
- **AC25/14.3** Circulate the Internal Audit Report on Charitable Funds.

It was resolved that the Committee:

- **RECEIVED** the progress report.
- **APPROVED** the changes to the plan for the Waiting List Initiative Payments (IHC Centre) review and the Integrated Assurance and Approval Plans (IAAP) for Wrexham Maelor Business Continuity.

EXTERNAL AUDIT

AC25/15 External Audit Progress Report

Members received the report and noted the progress made to date. In presenting the report, the Financial Audit Manager and Performance Audit Lead for Audit Wales highlighted:

- The team are aiming for the 28 January 2025 to complete the audit of the Awyr Las Charity Accounts 2023/24.
- Plans are in place for the 2024/25 draft accounts and subsequent audit and ongoing dialogue continues with the Director of Corporate Governance and Interim Executive Director of Finance.
- The team provided an update on the status of the current and planned performance audit work.
- The review of cost savings arrangements was issued in November 2024 and a management response has been received and the structured assessment was issued in December 2024.
- A report on Cancer Services has now been published and will be reported as part of the progress report at the next meeting.

In discussing the report, the Committee:

- Referred to recommendation 4 in the cost savings arrangements report and queried the impact and implications of the additional 10% savings requirement. It was confirmed that the 10% ask came from Welsh Government as a stretch target, this was not treated as an additional savings target and the Health Board delivered the savings ask.
- Suggested the need for Independent Members to gain a better understanding of the Health Board's finances and suggested a workshop style item could be provided.
- Queried how the savings and learning from the cost savings arrangements report will be progressed and embedded. It was confirmed that the work needs to start earlier to provide assurance. The majority of accountability agreements have now been signed off to agree baseline budgets and accountability. There is a need for the team to identify underlying deficits and also potential allocation to support ongoing pressure.

Actions:

- **AC25/15.1** Further support Independent Members to gain a deeper understanding of the organisation's finances.
- **AC25/15.2** Share the link for the Cancer Services report.

It was resolved that the Committee:

- **NOTED** the content of the report.

AC25/16 Structured Assessment

Members received the report and the Performance Audit Lead for Audit Wales highlighted:

- The report presented is the Structured Assessment for 2024, differing from the Structured Assessment for 2023 which was issued in May 2024. This unusually meant that the Committee had received two structured reports in the same financial year.
- There have been a number of positive findings including establishing a full cabinet of Independent Members providing scrutiny and valuable input, recruiting to some key posts and strengthening of the Board and Committee meetings where transparency is now being demonstrated effectively.
- There have been improvements in risk management, financial management and the overall financial position shared with the Board.
- There is a need to recruit to the remaining gaps in the Executive Team which once complete will ensure changes related to the Foundations for the Future Programme can be managed effectively.
- The Health Board are establishing key strategies and plans as well as a clinical services plan.
- The Board Assurance Framework is being strengthened and the team are working to ensure strategic objectives and risks are clear.
- Nine recommendations have been included in the report and the management response was noted as reasonable and comprehensive.

In discussing the report, the Committee:

- Thanked External Audit for the report highlighting the high level of engagement provided.
- Noted the challenges relating to the Executive Team and stated that progress is being made to recruit to some key appointments.

- Confirmed that there has been progress in relation to organisational governance and the introduction of the Foundations for the Future Programme will be a significant step forward to ensuring the organisation works more effectively.
- Referred to the positivity in providing openness and transparency and triangulation with the previous report highlighting the significant progress that has been made during the nine months since the last report was published.
- Queried appendix 2 and the progress made on the previous year recommendations, it was confirmed that some of these recommendations have now been included on the audit tracker, some processes are being revised to ensure they are robust and assurance was provided that all outstanding recommendations are being addressed. In particular recommendation 5 relating to recommendations made by non-audit bodies was discussed and the importance of notifying and reporting these via a tracking system was agreed as a priority.
- Acknowledged that the report will go to the Board in March 2025, works continues to assess progress against Special Measures and this report will support that work.

It was resolved that the Committee:

- **NOTED** the content of the report.

COUNTER FRAUD

AC25/17 Local Counter Fraud Service Progress Report (Q2)

Members received the report and the Head of Counter Fraud highlighted:

- The UK Government Functional Standard return was submitted last year, work is ongoing to address the amber rating and there is a need to ensure we are meeting those standards.
- We are unlikely to meet all the objectives included in the annual workplan due to difficulties with resources however the vast majority will be met.
- At the time of writing there were 37 open cases, this is now down to 35, a number of cases are historic and go back as far as 2018. Work is taking place to address how this number can be reduced and opportunities to make more robust and timely decisions on closure.
- Training continues to be delivered and BCU are the only Health Board in Wales that mandate an e-learning package. Face to face sessions have been conducted but not well attended.
- The Counter Fraud, Bribery and Corruption Policy is currently overdue, there has been a complete refresh of the policy, the policy has now gone out to consultation and will be presented to the Executive Policy Oversight Group in January 2025 and Audit Committee in March 2025 for approval.

In discussing the report, the Committee:

- Queried the risks included in the report and requested further detail is included in the report relating to mitigating measures being put in place to address the risks and progress to date.

Action:

- **AC25/17.1** Include additional information in the report in relation to the risks and progress.

It was resolved that the Committee:

- **CONSIDERED** and **NOTED** the content of the report.

FOR INFORMATION

AC25/18 Summary of Business to be Reported from Private

It was resolved that the Committee **NOTED** the report.

AC25/19 Committee Forward Workplan

It was resolved that the Committee **NOTED** the forward workplan for information.

CLOSING BUSINESS

AC25/20 Agree Items for Referral to Board / Other Committees

It was resolved that the following would be referred:

- Final Internal Audit Report on Consultant Job Planning to be included on the agenda for the next People and Culture Committee to monitor progress and oversight and an update to be provided back to the Audit Committee in six months' time.
- The current position on the LFERs and plans to address.
- Share the Internal Audit Report on Charitable Funds with the Charitable Funds Chair and Charitable Funds Committee.

AC25/21 Review of Meeting Effectiveness

In discussing the item, the Committee:

- Noted that there had been some good challenge on the audit recommendations and deeper discussion into items to provide benefits for moving forward.
- Created the right tone for constructive discussion and challenge, with the ability to draw on evidence and facts presented across all reports presented to facilitate deeper debate.
- Demonstrated good progress and challenge and the Committee felt assured in a number of areas.
- Acknowledged further work is required but good progress has been made over the past 18 months.
- Agreed that Executive Directors presenting limited and open recommendations provided a level of accountability.

AC25/22 Date of Next Meeting

Audit Committee Development Session: 20th February 2025, 9.30-11.00
Audit Committee: Thursday 4th March 2025, 9.30-13.30

Resolution to Exclude the Press and Public

'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be

transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Audit Committee Action Log (Public)

Updated 25.02.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			REMAIN OPEN			
1	**AC25/04.1**	16/01/25	**Matters Arising and Action Log (Trusted Assessor)** Board Development Session focussing on the role of the Trusted Assessor to be arranged.	Pam Wenger	~~March 25~~ Revised timescale Sept 25	**Remain Open** **10.02.25** The session will be added to the Board Development Programme and a suitable date arranged for 2025/26. This will not be before March 25 but will be planned before September 2025 as it would be helpful for the new COO to co-ordinate this session.
2	**AC25/06.2**	16/01/25	**Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub** Review introducing virtual sign off for capital programmes under the SFIs as part of the review of the SORD.	Russell Caldicott Pam Wenger	June 25	**Remain Open** **10.02.25** The review of the Scheme of Delegation has commenced; further work is required to align to the Foundations for the Future Programme and therefore suggest this will be finalised by end of May 2025.
3	**AC25/06.3**	16/01/25	**Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub** Follow up the governance element of	Russell Caldicott	~~March 25~~ Revised timescale April 25	**Remain Open** **25.02.25** Further request instructed 23 December 2024 – Health Board representatives seeking clarification as to why this remains outstanding.

			the lack of a project bank account, if it is considered to have been a breach of SFI's then report back to the Committee.			Escalated to Director of Environment
4	**AC25/07.1**	16/01/25	**Update Report on Internal and External Audit Recommendations** Invite the Executive Director of Nursing or Executive Director of Public Health to provide an update on their Internal and External Audit Recommendations at the next meeting.	Pam Wenger Angela Wood Jane Moore	~~March 25~~ Revised timescale April 25	**Remain Open** **10.02.25** The Executive Director of Nursing and Executive Director of Public Health are on leave on 4th March and will therefore be asked to join the next meeting in April 25. The Director of Performance & Commissioning has been invited to join the March 25 to provide a presentation.
5	**AC25/09.1**	16/01/25	**WRP Penalties – Learning from Events Report (LfER)** Share an example of an LfERs with the Independent Members - this will be done as part of a Board Development session.	Pam Wenger Matt Joyes	~~March 25~~ Revised timescale Sept 25	**Remain Open** **10.02.25** This has been included on the Board Development Programme. It is anticipated that this will take place before Sept 25 due to the amount of sessions on the schedule. LfERs are now shared with Board members when high value claims are submitted.
6	**AC25/10.1**	16/01/25	**Update on Health Board Policies and Written Control Documents** Summarise the policies that carry the biggest risk and provide a paper to the Committee in April 2025.	Pam Wenger Glesni Driver	April 25	**Remain Open** **04.02.25** A paper focussing on overdue policies will be presented to the meeting in April 25.
7	**AC24/151.1**	05/11/24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to	Pam Wenger Russell Caldicott	~~March 25~~ Revised	**Remain Open** **03.02.25** ToR have now been drafted and awaiting final review before

			Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.		timescale April 25	procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement) **08.01.25** An evaluation of the CfMHaS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review are currently being finalised in order that procurement for the review can be commissioned.
8	**AC24/151.2**	05/11/24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to Freedom of Information Request) Gain the opinion of the Information Commissioner on the FOI.	Pam Wenger Phil Meakin	~~Jan 25~~ ~~March 25~~ Revised timescale April 25	**Remain Open** **03.02.25** The Information Commissioner has received a copy of the FOI response. As of the 04.02.25 no response has been received from ICO to the Health Board. Monitoring of an anticipated response will continue from the Freedom of Information Team and communicated to Director of Corporate Governance when it is received. **08.01.25** Associate Director of Governance has followed this up. Communication with the Information Commissioners Office (ICO) commenced in September 24 and the Health Board is awaiting a response. (ICO communication normally takes 2-3 months).

9	**AC24.60.1.8**	07/05/24	**Internal Audit Progress Report** Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE Committee to drive progress on recommendations from the May 23 report.	Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE)	~~May 2024~~ ~~Nov 2024~~ ~~Jan 2025~~ Revised timescale May 2025	**Remain Open** **12.02.25** As the Director of Performance & Commissioning is now post, this will be considered at the QSE Committee in May 25. **08.01.25** An update on the progress against the Quality, Safety and Commissioned Services Report has been included on the forward plan for the QSE Committee. **24.10.24** Action to remain open and to be taken forward with the new Director of Planning & Commissioning. **02.09.24** PPJ confirmed that this has been referred to QSE Committee however the issue has not yet been resolved therefore the action remains open.
10	**AC24.60.1.10**	07/05/24	**Internal Audit Progress Report** Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Chairs Advisory Group as an emerging topic.	Karen Balmer Pam Wenger Philippa Peake-Jones	May 2025	**Remain Open** **08.01.25** The Head of Corporate Affairs has included this on the agenda for the next Chairs Advisory Group for discussion which is due to take place on 26.02.25. This meeting has subsequently been stood down and this item will roll over to the next meeting. **08.10.24** The recommendations included in the Lessons Learnt Audit Report have been shared with the

						Chair, this will be discussed at the Chairs Advisory Group in October and the Chair will provide a verbal update at the Audit Committee in November. **12.09.24** This will be discussed at the next Committee Chair's Meeting. **02.09.24** Update to be provided during the meeting. **18.07.24** To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair.
11	**AC24/121.1**	12/09/24	**Speak Up Safely** Share benchmarking information from other Health Boards in relation to the number of concerns being raised.	Jason Brannan Gareth Evans	~~Nov 2024~~ ~~Jan 2025~~ ~~March 25~~ Revised timescale May 2025	**Remain Open** **19.02.25** Tracey Eccles, SuS Guardian is working with colleagues across Wales to collate comparative data, this piece of work is ongoing and will be shared once finalised. This work aligns to the proposed review process noted in action AC24/121.1. **28.10.24** The Freedom to Speak Up Lead Guardian has begun liaising with colleagues from across the other Health Boards and will explore numbers of concerns as part of a benchmarking exercise, whilst also factoring in other considerations such as size of Health Board in relation to numbers of concerns received, and

						current impact factors that may also influence referral rates, e.g. impact of Special Measures and/or similar levels of external intervention into Health Boards.
12	**AC24/121.2**	12.09.24	**Speak Up Safely** Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.	Internal Audit Jason Brannan Gareth Evans	~~Nov 2024~~ ~~Jan 2025~~ ~~March 25~~ Revised timescale May 2025	**Remain Open** **19.02.25** An SBAR is being prepared to share with the Executive Team to gain approval to begin a process of review of the SuS framework and arrangements to include reviewing compliance and factors related to this included in the action tracker. Part of this review will include involving other stakeholders in the process to identify what the SuS Team currently provide from the perspective of a number of interested parties e.g. Trade Unions, Board Champions, Staff Networks, People Services, Information Governance, and if appropriate, Internal Audit. This will provide a more comprehensive review of the framework and approach and offer a greater level of assurance too. Speaking Up Safety is also included in the draft BCU Internal Audit Plan for 2025-26, which is being presented for approval at the March 25 meeting. **28.10.24** Speaking Up Safely as a

						mechanism and route to raising concerns was included in the Raising Concerns policy and process when first launched in July 2021, and again reviewed when the Raising Concerns policy and process was updated. The SUS team will engage in further work to explore any specific additions or adaptions to current practice that may be needed in relation to Public Disclosure (Whistleblowing) **16.09.24** Internal Audit will consider Speak Up Safely as a key risk area for the 2025/26 internal audit planning cycle following presentation of the report by Officers and observations made by Committee Members.
13	**AC24/124.3**	12/09/24	**Update on Health Board Policies and Written control Documents** It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future.	Pam Wenger Glesni Driver	~~Nov 2024~~ ~~Jan 2025~~ Revised timescale June 2025	**Remain Open** **03.02.25** Work on the Health Board policy review and approval processes has commenced, which will include a full consultation process, as well as a refresh of the 'Policy on Policies'. An update will be provided at the meeting in June 25. **10.12.24** A paper has been included on the agenda for the January meeting. Further work is required on policies once progress has been made against the current policies. **24.10.24** The immediate focus is

						reviewing the work in terms of the governance and overdue policies. There is opportunity to review the current processes going forward but given the focus on dealing with overdue policies this will be the immediate priority. This has been included on the forward workplan in terms of the long term review of the processes.
14	**AC24/127.4**	12/09/24	**Internal Audit Progress Report** Consider options for raising awareness and understanding of internal audit.	Pam Wenger Dave Harries	~~Nov 2024~~ ~~Jan 2025~~ ~~March 25~~ Revised timescale April 25	**Remain Open** **16.01.25** It was agreed during the meeting to keep this action open. The video will be shared at the Audit Committee Development Session on 20.02.25. A communication plan is being development across the organisation to understand how the Audit Plan is set up. An update on the Internal Audit video and the communication plan will be shared at the meeting in April 25. **28.11.24** A video is being developed to share with staff about the role of Internal Audit and Internal Audit have been included in the development. There will be an opportunity to consider the profile as part of the Annual Audit Plan. **03.10.24** PW to discuss options including developing video resource,

						an update will be provided in Jan 25.
			ACTIONS PROPOSED FOR CLOSURE			
1	**AC24/152.1**	05.11.24	**Conformance Report: Q2 2024/25** Provide an update on payroll procedures and the public sector payment policy at a private meeting if the issues aren't resolved.	Russell Caldicott Denise Roberts	~~Jan 2025~~ Revised timescale March 25	**Action proposed for closure** **25.02.25** This is now complete and forms part of the report.
2	**AC24/152.2**	05.11.24	**Conformance Report: Q2 2024/25** In section 3 of the report include a movement column in the table to highlight new, current and resolved cases.	Russell Caldicott Denise Roberts	~~Jan 2025~~ Revised timescale March 25	**Action proposed for closure** **25.02.25** This is now complete and forms part of the report.
3	**AC24/154.2**	05.11.24	**Internal Audit Progress Report** Russell Caldicott and Dave Harries to meet outside of the meeting to discuss the findings of the Final Audit report on the Llandudno Hospital Orthopaedic Surgical Hub.	Russell Caldicott Dave Harries Arwel Hughes	~~Jan 2025~~ Revised timescale March 25	**Action proposed for closure** **25.02.25** Escalated by Russ to CS, response forwarded approving final brief by CS. **09.01.25** Update from RC to follow. **06.12.24** A draft brief was shared with Russell Caldicott and Chris Stockport has now approved the final brief.
4	**AC24/154.5**	05.11.24	**Internal Audit Progress Report** Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy.	Russell Caldicott Arwel Hughes	~~Jan 2025~~ Revised timescale March 25	**Action proposed for closure** **25.02.25** Action to be taken forward by SK. **09.01.25** Update from RC to follow.
5	**AC25/15.1**	16.01.25	**External Audit Progress Report** Further support Independent Members to gain a deeper understanding of the organisation's finances.	Russell Caldicott	March 25	**Action proposed for closure** **25.02.25** Board Development Session took place in January.

6	**AC24/147.2**	05.11.24	**Update on Outstanding Audit Recommendations** Work with WOD to understand how budgetary training can link in with ESR.	Russell Caldicott Michelle Jones	~~Jan 2025~~ Revised timescale March 25	**Action proposed for closure** **25.02.25** Finance training includes WOD representation.
7	**AC25/14.1**	16.01.25	**Internal Audit Progress Report** Russell Caldicott and Simon Cookson to discuss gaining unrestricted access to data outside of the meeting.	Russell Caldicott Simon Cookson	March 25	**Action proposed for closure** **13.02.25** This has been resolved from an Internal Audit perspective, the majority of information has been provided, outstanding information has been approved and being gathered.
8	**AC25/05.1**	16/01/25	**Update on Outstanding Audit Recommendations** Learning from the Final Audit Report on Effective Governance (IHC Central) to be shared with the other IHCs and pan BCU.	Imran Devji Gareth Evans Naomi Holder	March 25	**Action proposed for closure** **07.02.25** Central IHC will share the information on Learning from the Final Audit Report on Effective Governance at the next Operational Leadership Team meeting which is taking place on the 11 February 2025.
9	**AC25/06.1**	16/01/25	**Update on Open Audit Recommendations – Audit Wales Community Pharmacy Data Matching Pilot** Head of Counter Fraud to review the Audit Wales Community Pharmacy Data Matching Pilot and provide an update as part of the Counter Fraud Progress Report.	Danielle Timmins	March 25	**Action proposed for closure** **10.02.25** The Head of Counter Fraud has confirmed that this will be included in the report that is being presented to the Committee in March 25.

10	**AC25/06.4**	16/01/25	**Update on Open Audit Recommendations – Final Internal Audit Report on Consultant Job Planning** Progress and oversight of the Final Internal Audit Report on Consultant Job Planning to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.	Pam Wenger Sree Andole Nick Graham	Aug 25	**Action proposed for closure** **10.02.25** The Report is due to go to the next meeting of the P&C Committee in Feb 25 to discuss and confirm the frequency of reporting into the P&C Committee. This has also been included on the forward workplan for the Audit Committee in Aug 25.
11	**AC25/09.2**	16/01/25	**WRP Penalties – Learning from Events Report (LfER)** Report to the Integrated Performance Executive Delivery Group and ensure the Audit Committee have oversight of those not responding by providing updates via the Quarterly Conformance Report produced by the Finance Team.	Russell Caldicott Matt Joyes	March 25	**Action proposed for closure** **14.02.25** Legal Services have been working with Finance to provide data for the quarterly Conformance Report. The LfER position has also been escalated for ongoing monitoring by the Executive Integrated Performance Delivery Group.
12	**AC25/11.1**	16/01/25	**Board Assurance Framework** Amend the wording to show Red = Negative assurance: the Committee is satisfied that there is insufficient reliable evidence. Refine the use of the word risk under the principal risks (use more simple language)	Pam Wenger Nesta Collingridge	March 25	**Action proposed for closure** **04.02.25** The suggested changes have been made and the revised version was presented to the Board in Jan 25.
13	**AC25/13.1**	16/01/25	**Annual Report 2024/25 Arrangements** Change the date of the Audit Committee to from 25/06/25 to 24/06/25 (preferably morning).	Philippa Peake-Jones Laura Jones	March 25	**Action proposed for closure** **10.02.25** The Audit Committee in June will take place on 24.06.25, 9-12.30pm.

14	**AC25/14.2**	16/01/25	**Internal Audit Progress Report** Share full copies of all Internal Audit Reports going forward.	Philippa Peake-Jones Laura Jones	March 25	**Action proposed for closure** **10.02.25** All Internal Audit Report received since June 24 have been added to the Teams Channel for Independent Members and any further Reports received will be added.
15	**AC25/14.3**	16/01/25	**Internal Audit Progress Report** Circulate the Internal Audit Report on Charitable Funds.	Philippa Peake-Jones Laura Jones	March 25	**Action proposed for closure** **10.02.25** This document has been shared with the Committee via email.
16	**AC25/15.2**	16.01.25	**External Audit Progress Report** Share the link for the Cancer Services report.	Fflur Jones	March 25	**Action proposed for closure** **20.02.25** The link has been shared with the Committee via email.
17	**AC25/17.1**	16/01/25	**Local Counter Fraud Service Progress Report (Q2)** Include additional information in the report in relation to the risks and progress.	Danielle Timmins	March 25	**Action proposed for closure** **10.02.25** The Head of Counter Fraud has confirmed that this will be included in the report that is being presented to the Committee in March 25.
18	**AC24/127.2**	12.09.24	**Internal Audit Progress Report** EPRR/Civil contingencies will go to the PPHP Committee in October and feedback on the discussion will be provided back to the Audit Committee.	Pam Wenger	~~Nov 2024~~ ~~Jan 2025~~ ~~March 25~~ Revised timescale April 25	**Action proposed for closure** **06.02.25** The Head of Risk Management and EPRR Lead have drafted a response in order to ensure corporate risks are reviewed and operational EPRR risks are documented. A response has been drafted for the Risk Scrutiny Group for assurance, as well as the PPHP Committee in February 25 and will be included in the Risk Governance Report being presented to the Audit

						Committee at the March 25 meeting. **25.11.24** An item focussing on the EPRR Risks will be considered by the PPHP Committee at the meeting on 18.02.25. **03.10.24** A report on EPRR was considered at the PPHP Committee on 22.10.24 and it was agreed for the next meeting to receive an update in terms of the risks. The issue of the deferred audit was discussed and recognised that the Internal Audit Team had no option but to defer the audit.
19	**AC24.62.1.4**	07.05.24	**Local Counter Fraud** F03 BCUHB Counter Fraud Policy is due for review – to be approved by August 2024. (Audit Committee Agenda in September)	Russell Caldicott Danielle Timmins Sjef Molmans	~~Sept 2024~~ ~~Nov 2024~~ ~~Jan 2025~~ ~~March 25~~ Revised timescale April 25	**Action proposed for closure** **20.02.25** The Counter Fraud Policy is included on the agenda for the meeting in March 25. **10.02.25** The policy was approved by the Executive Policy Oversight Group in January 25 and will go to the Executive Committee in February 25 before being presented to the Audit Committee in March 25. **25.10.24** With the recent appointment of the Head of Counter Fraud and the continued difficulties within the team owing to absence, the policy review has been deferred to the next Audit Committee for ratification with advice taken from

						national leads as to whether this offers a risk in relation to the recent changes in legislation. **12.09.24** RC to review the policy and check whether the legislation is due in September 24. **05.09.24** The Counter Fraud Policy required further work and has been included on the forward workplan for the November meeting. **26.06.24** Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July. **20.05.24** Item now on CoB for September 2024.
Closed Actions (as agreed at meeting on 16.01.25)						
Action	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**AC24.43.6**	15.03.24	**Annual Timetable 23-24 Draft Final Accounts** To feedback to Committee in relation to the levels of exposure costs in terms of Welsh Risk Pool payments.	Russell Caldicott	~~May 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**28.11.24** A paper on the penalties from the Welsh Risk Pool has been included on the agenda for the January 25 meeting. **05.11.24** Committee lack of learning from events report. Risk pool penalties are going up Legal function has just transferred over to Pam. The challenge is that we haven't been able to evidence the learning. There will be a legal update at the next QSE meeting, looking at setting up a sub

						committee on legal and risk, acknowledge the position, further work to be completed. **29.10.24** A paper on penalties from the Welsh Risk Pool has been include on the agenda for the November meeting. **03.05.24** Update to be provided at the meeting.
2	**AC24.57.7.5**	07.05.24	**Audit Tracker** The need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis was raised. It was agreed that the process for external audits needed to be different to the proposal in 2.1 of the report.	Pam Wenger Russell Caldicott	~~July 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**08.01.25** The paper on the agenda includes a proposal in terms of closure of external audit recommendations. **10.12.24** Director of Corporate Governance to meet with Fflur Jones, External Audit, 11.12.24 to discuss. **02.09.24** Director of Corporate Governance to discuss with External Audit to agree closure process. **03.07.24** Process to be developed and agreed with External Audit following the end of year accounts process being concluded.
3	**AC24.94.9**	18.07.24	**Effective Governance – IHC Central Final Internal Audit Report** The Chair of the Committee referred to the number of open complaints since April, and questioned the position at the end of June. The Director agreed to forward the detail to the Chair following the meeting, it	~~IHC Director Central (Libby Ryan Davies)~~ Gareth Evans	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**28.11.24** Gareth Evans & Naomi Holder are due to join the January meeting to provide an update. **08.10.24** The Central IHC have provided a positional update of formal complaints and this has been included as an attachment to the action log (items AC24/145.2 &

			was noted that overdue complaints had significantly reduced. It was also agreed to provide a future update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting.			AC24/145.3). The IHC will be invited to attend the meeting in Jan 25 to provide an update on the impact of the actions being taken. **03.09.24** Since the July meeting there has been a change in the IHC Director Central role. The team are aware of the action and will provide a response ahead of the November meeting.
4	**AC24.99.8**	18.07.24	**Annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024** The Committee Chair requested details on the availability of comparative trend analysis, including geographical data (in relation to East, Central and West IHC areas). The All Wales Post Payment Verification (PPV) Manager (NWSSP) agreed to provide this information.	Amanda Legge	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**09.12.24** Trend data and supporting narrative circulated by email. **05.11.24** Update provided during meeting that the Committee are happy for information to be shared outside of the meeting. **24.10.24** The prototype is still in development, the relevant data can be extracted and presented as an internal report, Committee to confirm whether they want this report to be presented at the next meeting in Jan 25 or for information to be shared outside of the meeting. **02.09.24** Amanda Legge confirmed that this information can be provide by locality area (e.g. Flintshire, Wrexham, Denbighshire, Conwy, Gwynedd & Anglesey). A prototype is being developed to include trend data and will be shared once available.

5	**AC24.99.9**	18.07.24	**Annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024** The Director of Corporate Governance questioned if any particular themes had been raised upon the visits in terms of learning, and of the resolutions or progress and (where applicable) to counter fraud. The NWSSP Lead provided an overview of the current actions taken and it was agreed to include any anonymised common themes within future reports to the Committee.	Amanda Legge	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**09.12.24** Trend data and supporting narrative circulated by email. **05.11.24** As per update for action above. **24.10.24** As per update for action above. **02.09.24** As per action above AC24.99.8 the information being collated will include any issues and common themes.
6	**AC24/124.2**	12.09.24	**Update on Health Board Policies and Written control Documents** A summary to be provided at the next meeting as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.	Pam Wenger Glesni Driver	Jan 2025	**03.12.24** This will be covered in the Policy Update Report at the January 25 meeting. **24.10.24** Work is in progress; this is being progressed via the Policy Oversight Group and the Executive Team. This will come to the Committee in January 25.
7	**AC24/145.1**	05.11.24	**Matters Arising & Action Log** Share paper that Imran Devji took to PFIG regarding the role of the Trusted Assessor.	Pam Wenger	Jan 2025	**16.01.25** Agreed to close the action and open additional action AC25/04.1 to arrange a Board Development session on the role of the Trusted Assessor. **26.11.24** The document has been shared with the Committee via email
8	**AC24/145.2**	05.11.24	**Matters Arising & Action Log** Circulate the Complaints	Philippa Peake-Jones	Jan 2025	**05.11.24** PPJ circulated the document to the Committee via email

			Improvement Deep Dive from the October QSE Committee.			
9	**AC24/146.1**	05.11.24	**Update Report on Internal and External Audit Recommendations** Invite Imran Devji to attend the next meeting to provide an update on the Internal and External Audit Recommendations for the Chief Operating Officer.	Philippa Peake-Jones	Jan 2025	**25.11.24** Imran Devji will attend the January 25 meeting to give a presentation on outstanding Audit recommendations.
10	**AC24/146.2**	05.11.24	**Update Report on Internal and External Audit Recommendations** Bring a paper to the next meeting relating to external audit recommendations for closure approval and a paper relating to historic external audit recommendations.	Pam Wenger Glesni Driver	Jan 2025	**28.11.24** A paper on Historical External Audit Recommendations has been included on the agenda for the January 25 meeting.
11	**AC24/147.1**	05.11.24	**Update on Outstanding Audit Recommendations** Share the Interim Executive Director of Finance update presentation on open audit recommendations.	Philippa Peake-Jones	Jan 2025	**05.11.24** PPJ circulated the document to the Committee via email
12	**AC24/147.3**	05.11.24	**Update on Outstanding Audit Recommendations** Share the Budget Manager Handbook with the Committee.	Russell Caldicott Andrea Hughes	Jan 2025	**26.11.24** The Budget Manager Handbook has been shared with the Committee via email
13	**AC24/147.4**	05.11.24	**Update on Outstanding Audit Recommendations** Share the presentation from the CEO on Foundations for the Future Programme with the Committee.	Pam Wenger	Jan 2025	**25.11.24** The CEO Foundations for the Future Programme presentation was uploaded to iBabs for all Board members following the Board Development session held on

						31.10.24
14	**AC24/147.5**	05.11.24	**Update on Outstanding Audit Recommendations** Urtha Felda and Dyfed Jones to discuss the suggestion of a Health Board Lottery.	Urtha Felda Dyfed Jones	Jan 2025	**27.11.24** Urtha & Dyfed have discussed the implications of the Board promoting an activity which causes addiction and harm to individuals and their families. It has been agreed that going forward Dyfed will request input from Urtha if any related item are included on the agenda for the Charitable Funds Committee.
15	**AC24/153.1**	05.11.24	**Penalties from the Welsh Risk Pool** As part of the process and review of Legal Services look at quality and a potential Deep Dive.	Pam Wenger	Jan 2025	**28.11.24** A paper has been included on the agenda for the January 25 meeting to address this action.
16	**AC24/153.2**	05.11.24	**Penalties from the Welsh Risk Pool** Review the penalties incurred via the Welsh Risk Pool in terms of risk and financial implication and bring this back to the Committee in January 25. Assess whether this information could form part of the quarterly Conformance Report going forward.	Russell Caldicott Andrea Hughes	Jan 2025	**28.11.24** A paper has been included on the agenda for the January 25 meeting to address this action.
17	**AC24/154.1**	05.11.24	**Internal Audit Progress Report** Ensure Independent Members are updated with regards to failure for management to respond to Internal Audit Recommendations.	Dave Harries	Jan 2025	**06.12.24** Internal Audit will include details in progress reports where they encounter untimely responses to reports. In addition, where management do not accept a recommendation, Internal Audit will raise this at Committee where they believe the risk is such that the Audit

						Committee need to be aware.
18	**AC24/154.3**	05.11.24	**Internal Audit Progress Report** Circulate relevant minute from the Health Board meeting in relation to the effective award of contract and delegation of approval of the Llandudno Hospital Orthopaedic Surgical Hub.	Philippa Peake-Jones	Jan 2025	**26.11.24** The extract from the Health Board minutes held in September 2023 has been circulated to members for information (noting this is not for wider circulation)
19	**AC24/154.4**	05.11.24	**Internal Audit Progress Report** Due to the lack of regular oversight of the Llandudno Hospital Orthopaedic Surgical Hub, note this via PFIG Committee and provide an update back to the Committee and invite Chris Stockport to join the January 25 meeting.	Pam Wenger Philippa Peake-Jones	Jan 2025	**28.11.24** Chris Stockport and Nicola Etherington will join the January 25 meeting to discuss the Llandudno Hospital Audit to address this action.
20	**AC24.101.13**	18.07.24	**Internal Audit Progress Report** An IM requested clarification on the role of the Trusted Assessor and the strengthening of this role within the overall process. The Director of Corporate Governance noted the request and agreed to arrange for the clarification to be provided to all Independent Members.	Pam Wenger	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**16.01.25** Agreed to close the action and open additional action AC25/04.1 to arrange a Board Development session on the role of the Trusted Assessor. **26.11.24** A paper on the Trusted Assessor Role Guidance has been shared with the Committee via email. **03.10.24** A paper on Urgent and Emergency Care was presented to the Board in September which covered the role of the Trusted Assessor. Committee to confirm whether further action is required. **12.09.24** This will be covered in a

						paper going to the Board in September on Urgent and Emergency Care and is part of the work taking place with Local Government. **04.09.24** Briefing on the role of the Trusted Assessor to be commissioned.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Information Governance and Records Management Position Update</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Audit Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4"></td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">BCUHB has a responsibility to ensure robust information governance systems and processes are in place to protect patient, personal and corporate information.

Following the external breach of the EY Report, an external review of the Health Board’s information governance and records management systems and processes was undertaken during June and July 2023.

This report provides the Audit Committee with an update on the current position on the findings and the next steps required to fully complete all recommendations.

The findings included 8 recommendations with a total of 48 actions of which
• 36 have been completed;
• 10 are continuing to be progressed;
• 2 have not been progressed due to significant resource requirements.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to note the assurance provided on compliance with the identified recommendations and the next steps required to address the areas of shortfall.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Dylan Roberts - Chief Digital and Information Officer</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Justine Parry, Data Protection Officer / Assistant Director of Compliance and Business Management

Carol Johnson, Head of Information Governance</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="2">I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
</table>

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016. • Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation. • Learn from outcomes and put improvement plans in place to ensure lessons can be learnt and acted upon to avoid reoccurrence.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Data Protection Act and Freedom of Information Act
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board's ability to protect the privacy of their information. **CRR24-07**: Availability and Integrity of Patient Information **CRR24-17**: ICT Failure and Cyber
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Approved by responsible Director on the 18th December 2024

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**BAF24-02: Risk of Ineffective Strategic Development and Digital Transformation -** Ineffective strategy development, robust planning processes, and a forward-looking approach to digital technology to ensure long-lasting organisational change. **BAF24-08: Inability to initiate and implement evidence-based improvement and innovation -** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Next Steps:

1. Information Governance Team to continue to support other departments with remaining partially completed actions.
2. Digital, Data and Technology Department to submit a further bid for funding to support the Executive Decision for Option 2 to secure resources to appoint a Corporate Records Specialist and project support to scope out a Corporate Records Management Function including the requirements to implement a document classification scheme.

Rhestr o Atodiadau:
List of Appendices:

Appendix 1 – Information Governance and Records Management Position update for the Rapid Review external audit undertaken June 2023.

Appendix 2 – Information Governance and Records Management External Review Update – December 2024.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Appendix 1: Information Governance and Records Management

Position update for the Rapid Review external audit undertaken June 2023

Information Governance and Records Management

The purpose of this report is to:

Provide the Audit Committee with an update in respect of the current position with the findings from the external Information Governance and Records Management external review which took place in June / July 2023.

The paper aims to provide assurance to the Committee by outlining the current position and the plans in place to monitor the progress of the report recommendations.

There were 8 recommendations with a total of 48 actions recorded within them.

There are several high-level recommendations with associated actions within the report which are a mix of short-term fixes and more strategic long-term commitments that will require larger projects of work and resources to complete.

The Information Governance Team continue to co-ordinate the progress and improvements needed to meet the recommendations.

Progress reports are provided to the Information Governance Group, and the Performance, Finance and Information Governance Committee on a quarterly basis with the last one being in November 2024. Following the previous submission to the Committee, it was proposed that this follow up report be presented to the Audit Committee for awareness on the activity.

This report highlights the areas that are still outstanding. Whilst the recommendations were made as a result of an Information Governance review it should be noted that there are larger pieces of work outside the control of the Information Governance Department remit and ability to meet. Work continues to support other Departments to deliver on those requirements.

As of the 3rd December 2024 please find the current positions of the 48 actions below:

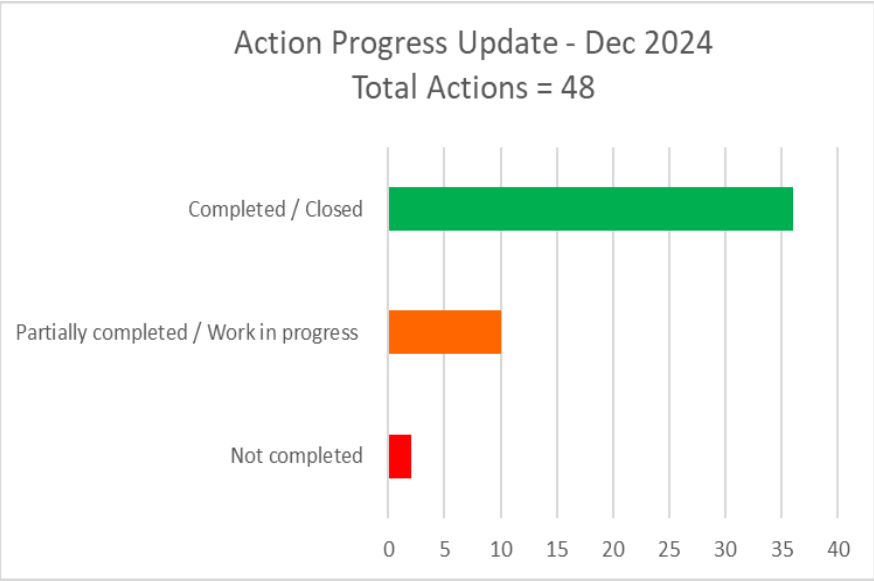
12 actions remaining open, with 36 having been completed. Work is still ongoing for 10 of the actions which are partially complete. 2 of the actions remain incomplete.

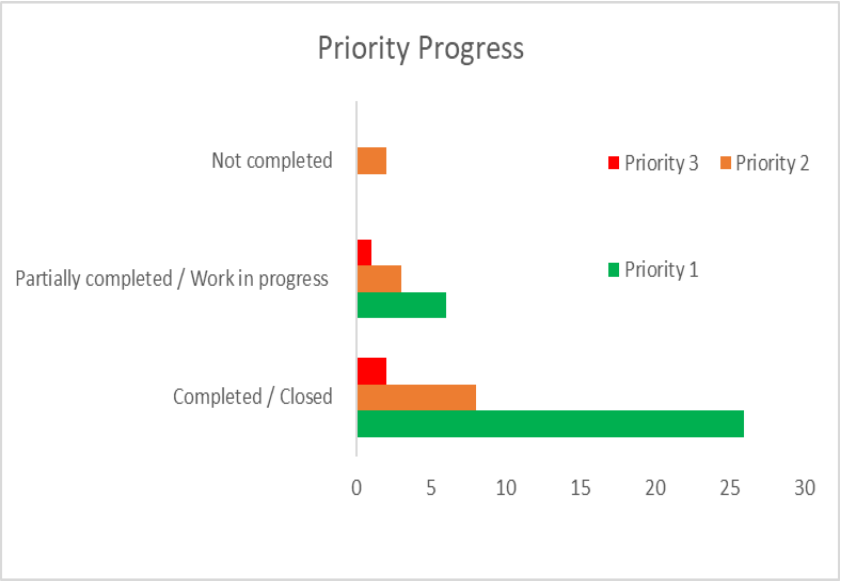
- 36 actions have been fully completed;
- 10 actions are partially complete with work still in progress and / or additional action plans in place to progress these through to completion. It should be noted that 6 of the actions relate to the work being undertaken with the new Information Asset Register so will be closed on completion of the training.
- 2 actions have not been completed with no resources in place to deliver through to completion. Further details can be found below.

Please refer to Appendix 2 for further information regarding the current position and remaining actions:

Appendix 2

Information Governance and Records Management External Review Update – December 2024





Action	Position	Comments
Health Board to develop a Strategic Outline Case to progress Corporate Records Management function.	**Incomplete**	A paper was presented to the Executive Team on the 11th October 2023 with Option 2 being approved to appoint a Corporate Records specialist and project support to establish a Corporate Records Management Service. Due to the lack of available funding this has not progressed. The original paper has been re-presented to the Executive Team in November 2024 to agree to reverse this to Option 1 which is to do nothing and to continue with the current arrangements currently being facilitated by the Information Governance Department. A further bid for funding with be presented to Executive Team in 2025/26 by the Corporate Records Lead/Chief Digital Information Officer. **It should be noted this action cannot be completed until the resources are in place.**

Action	Position	Comments
That the Health Board consider developing a records classification scheme which is a method used to categorise, mark, and organise records to aid compliance with legal and security requirements.	**Incomplete**	**It should be noted this action cannot be completed until there is agreement across the Health Board to introduce a Classification Scheme which will require a project/task and finish group as a minimum.**
Office of the Board Secretary look to review the Publication Scheme	**Partial**	The Information Governance Team have completed a review of the current Publication Scheme including checking all links and current information. A full review and update from Office of the Board of Secretary is awaited with regards to any additional information which could be included. Wider conversations are being held to establish the feasibility of additional data sets for publication to enable more transparency and improve efficiencies.
Access Control Policy	**Partial**	Local Access Control Policy being developed by the Head of Cyber Security.
IT consider if there are any additional safeguards that can be implemented for printing to reduce the risks of documents being disclosed inappropriately.	**Partial**	A review has been undertaken of the existing SafeQ installation and server infrastructure by the ICT Department, the printer supplier and software vendor. There has been a complete redesign of the implemented solution to allow for better scalability and resilience and this is currently in testing phase. Once the new environment has been signed off, migration of the existing SafeQ enabled Printers onto the new environment will commence as well as the ability to add additional devices when required.
That Information Asset Owners are reminded of their responsibilities in relation to retention and destruction of information.	**Partial**	These actions form part of the wider project and role out of the new Information Asset Register. Training plans are in place and formal training sessions have commenced. This covers responsibilities and accountability for the full lifecycle of an Information Asset. Training tools and videos have been made available. Responsibility for the above is being managed jointly by Information Governance, Cyber Security and ICT Teams.
That a review be undertaken of Information Asset Owners to ensure that they remain current and that they are reminded of their responsibilities.	**Partial**	
That rapid training for Information Asset Owners is provided due to turn over and apparent confusion over who the Information Asset Owners are.	**Partial**	

Action	Position	Comments
That the Health Board consider establishing a Community of Interest where Information Asset Owners can share/ask questions, guidance etc. with each other and of the Information Governance Team.	**Partial**	
That a list of Information Asset Owners be published on the intranet.	**Partial**	
That Information Asset Owners ensure that the Information Asset Registers / Records of Processing Activity are reviewed and updated.	**Partial**	
That a Data Protection Impact Assessment be undertaken for use of social media / social media platforms.	**Partial**	The Health Board local Data Protection Impact Assessment has been approved, whilst the national Data Protection Impact Assessment is still in draft form.

Teitl adroddiad: ***Report title:***	Risk Report & Corporate Risk Register
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 04 March 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register (Appendix 2) and provide and update on the Risk Governance arrangements (Appendix 3). The Committee is asked to note changes approved by the Executive Team: • **Target dates extensions**: o Patient Safety o Failure to embed learning o Health and Safety • **Risks for closure:** o CRR24-12 'Areas of Clinical Concern' – Risk has been closed and 7 new clinical Corporate Risks have been developed and approved by the relevant Executive: • **Risks opened:** o CRR24-20 – Oncology Service o CRR24-21 – Ophthalmology Service o CRR24-22 – Orthodontics Service o CRR24-23 – Vascular Service o CRR24-24 – Renal Service o CRR24-25 – Dermatology & Plastic Surgery Service o CRR24-26 – Urology Service • **Score Reductions:** o CRR24-18 'Operational Planning for Transmittable Diseases and Outbreaks' – Following Deep Dive of the risk at the Risk Scrutiny Group November 2024 meeting and subsequent discussion at Executive Team the risk score for the risk has been reduced from a current score of 20 (Impact 4 x Likelihood 5 = 20) to a current score of 16 (Impact 4 x Likelihood 4 = 16). This paper reflects this approved change. **To note**: Good progress on actions; Of the 24 Corporate Risks, 160 actions have been developed to mitigate the risks 26 actions have been completed since Nov 24 report, 117 actions are progressing and on track, with 15 new actions identified. **To note**: Good progress on risk governance KPIs; Appendix 3 outlines the Risk Governance arrangement report that was presented to the Risk Scrutiny Group during the February 2025 meeting highlighting the current position in relation to Risk audits undertaken within services and current improved position in relation to Risk Management. To note: Review of Emergency Preparedness within risks ; The group is asked to note Appendix 4 'Emergency Preparedness Review of Risks', which highlights the continued and ongoing work by the

	Emergency Preparedness Team to support Civil Contingencies preparedness. Appendix 1 – Corporate Risk Register Dashboard Appendix 2 - Full Corporate Risk Register as of January 2025. Appendix 3 - Risk Governance Arrangement report February 2025 Appendix 4 - Emergency Preparedness Review of Risks.
Argymhellion: ***Recommendations:***	The Committee is asked to **note**: 1. The Corporate Risk Register as reported to Risk Scrutiny Group Jan 25* 2. Risk Governance arrangements paper and updates.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework due for review
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Quality assurance by Corporate Risk Management Team and some have been updated and presented to Risk Scrutiny Group, Executive Team and relevant Committees.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	**N/A** **Cyber risk CRR24-17 excluded from the paper**
Camau Nesaf: ***Next Steps:*** 1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle. 2. Submission of Corporate Risks to Board. 3. Continuation of Risk Audits carried out within services.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1 – Corporate Risk Register Dashboard Jan 25 • Appendix 2 – Corporate Risk Register Report Jan 25 • Appendix 3 – Risk Governance Arrangements Report Feb 25	

- Appendix 4 – Emergency Preparedness Review of Risks Feb 25

Corporate Risk Register & Risk Report

Corporate Risk Register Report

1.0 Purpose

The purpose of this report is to provide an update to the Committee on the Corporate Risk Register.

1.1 Key Highlights

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

- **CRR24-02 '**Patient Safety' – Extend the target risk due date approved by the Executive Team from the 31/03/2025 to 30/09/2025.
- **CRR24-04 '**Failure to embed learning' – Extend the target risk due date approved by the Executive Team from the 31/03/2025 to 30/09/2025.
- **CRR24-15** 'Health and Safety' – Target date extend the risk due date from the 31/12/2025 to the 31/03/2026, as previously noted to RSG to allow sufficient time to complete and implement the actions identified, with some actions not due to commence until the new financial year 2025-26.

The following risks were subject to a deep dive at the January 2025 Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

- **CRR24-09 –** Primary Care
- **CRR24-19** – Community Care Provision

1.2 Changes in Score

Risk Ref	Reduced Risks	Lead Exec Director	Previous Risk Score	Current Risk Score
CRR24-18	Operational Planning for Transmittable Diseases and Outbreaks	Executive Director of Public Health	**20 (September 2024)**	**16 (4x4)**

1.3 New Risks

The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-20	Oncology Service	Interim Executive Medical Director	**15 (3x5)**
CRR24-21	Ophthalmology Service	Interim Chief Operating Officer	**20 (4x5)**

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-22	Orthodontic Service	Interim Chief Operating Officer	**16 (4x4)**
CRR24-23	Vascular Service	Interim Chief Operating Officer	**16 (4x4)**
CRR24-24	Renal Service	Interim Chief Operating Officer	**16 (4x4)**
CRR24-25	Dermatology & Plastic Surgery Service	Interim Executive Medical Director	**15 (3x5)**
CRR24-26	Urology Service	Interim Executive Medical Director	**16 (4x4)**

1.4 Overdue/Delayed Actions

The corporate risk register report was produced at the beginning of Jan 25 which did not note any actions as 'overdue' however several actions are noted for being due end of Jan 25.

As per the normal cycle of reporting, the March 25 updates are being sought for current updates on all of these actions. The status of these actions of will be included in the next update/iteration of the risk register.

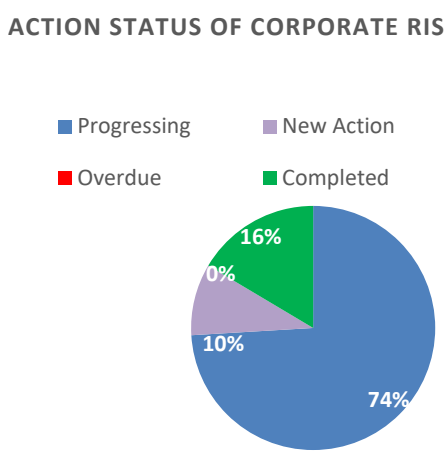
1.5 Risks above Health Board 24/25 appetite

Eight risks reported to committee score **above** the tolerance range set in the appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR24-05	Financial Sustainability	Executive Director of Finance	**20**	**Financial 15-19**
CRR24-06	Suitability and Safety of Sites	Executive Director of Finance	**20**	**Quality 15-19**
CRR24-09	Primary Care	Executive Director of Operations	**20**	**Quality 15-19**
CRR24-10	Urgent and Emergency Care	Interim Chief Operating Officer	**20**	**Quality 15-19**
CRR24-11	Planned Care	Interim Chief Operating Officer	**20**	**Quality 15-19**
CRR24-13	Timely Diagnostics	Interim Chief Operating Officer	**20**	**Quality 15-19**
CRR24-19	Community Care Provision	Executive Director of Transformation and Strategic Planning	**20**	**Quality 15-19**

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR24-21	Ophthalmology Service	Interim Chief Operating Officer	**20**	**Quality 15-19**

1.6 Action Plan status of Corporate Risks



Of the 24 Corporate Risks, 160 actions have been developed to mitigate the risks 26 actions have been completed, 117 actions are progressing and on track, with 15 new actions identified. No actions are overdue (beginning of Jan 25).

Risk Governance Arrangements

2.0 Risk Governance Arrangements Maturity Report

Risk Governance Arrangement Report (**Appendix 3**) presents items of assurance and escalation to the Committee over matters of governance in relation to Directorates managing their Operational Risk Registers, as well as an overview of BCUHBs Risk Key Performance Indicators (KPI's) and the most recent high risks reported.

3.0 Emergency Preparedness Review of Risks

The group is asked to note **Appendix 4** 'Emergency Preparedness Review of Risks', which highlights the continued and ongoing work with the Head of Risk Management and the Emergency Preparedness Team to support Civil Contingencies preparedness following the commencement in post of the Emergency Preparedness Resilience Response (EPRR) Lead in July 2024. An action from Planning, Population Health & Partnership Committee was for the EPRR Lead and Head of Risk Management to review the Corporate Risk Register.

Next steps

1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.
2. Submission of Corporate Risks to Board
3. Continuation of Risk Audits carried out within services.

Appendix 1 – Corporate Risk Register Dashboard Jan 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ⟷	8	Quality / Open 15-19	People & Culture Committee	Opened Dec 23. 12 actions identified, 2 completed, 6 progressing with 4 progressing with revised due dates. Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 31/12/2025 to the 31/03/2026
EDoN	CRR24-02	Patient Safety	4 x 4 = 16 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 4 actions identified, 1 completed, and 3 actions progressing (1 with revised due dates). **Proposal to extend target risk due date from 31/03/2025 to 30/09/2025.**
EDoN	CRR24-04	Failure to Embed Learning	5 x 3 = 15 ⟷	5	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 5 actions identified, 1 completed, 1 progressing with revised due date and 3 new action identified. Reduction in current risk score from 20 to 15 – September 2024. **Proposal to extend target risk due date from 31/03/2025 to 30/09/2025.**
EDoF	CRR24-05	Financial Sustainability	4 x 5 = 20 ⟷	12	Financial / Open 15-19	Performance, Finance and Information Governance Committee	Risk score has remained at 20 since opened in March 2023, updated to reflect current financial year. 1 progressing action ongoing. **Risk Score above tolerance set in risk appetite.**
EDoF	CRR24-06	Suitability and Safety of Sites	4 x 5 = 20 ⟷	12	Quality / Open 15-19	Performance, Finance and Information Governance Committee	Opened March 24, 4 actions identified, 4 progressing **Risk Score above tolerance set in risk appetite.**

CDIO	CRR24-07	Fragmented Patient Care Record	4 x 4 = 16 ⟷	12	Quality Open 15-19	Planning, Population Health & Partnership Committee	Opened Dec 23, 8 actions identified, 6 progressing (with 2 revised dates) and 2 new actions. Reduction in current risk score from 20 to 16 – September 2024.
EDoPH	CRR24-08	Delivering a population health approach to health and wellbeing	4 x 4 = 16 ⟷	12	Quality Open 15-19	Planning, Population Health & Partnership Committee	Opened Nov 2023. 8 actions identified, 1 completed, 6 progressing (with 2 revised dates), with 1 new action identified. Reduction in current risk score from 20 to 16 – September 2024.
EDoO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 7 actions identified, all 7 progressing, with 3 revised due dates. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-10	Urgent and Emergency Care	5 x 4 = 20 ⟷	12	Quality Open 15-19	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions progressing, with 2 revised dates. **Risk Score above tolerance set in risk appetite. Inherent impact score of 5 revised from 4 to 5 and likelihood of 5 to 4. Overall score remains the same.**
COO	CRR24-11	Planned Care	5 x 4 = 20 ⟷	8	Quality Open 15-19	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions identified, 3 progressing, with 1 action completed. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions progressing, with 1 revised date. **Risk Score above tolerance set in risk appetite. Inherent impact score of 5 revised from 4 to 5 and likelihood of 5 to 4. Overall score remains the same.**

							Executive Lead for the risk updated and amended from the Executive Director of Allied Health Professions & Health Science to the Chief Operating Officer.
EDoTH	CRR24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⟷	8	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 4 actions identified, all 4 progressing with revised due dates.
EDoW	CRR24-15	Health and Safety	4 x 4 = 16 ⟷	8	Regulatory Seek 20-25	People & Culture Committee	Opened Nov 2023. 10 actions identified, 8 progressing, with 2 actions not yet commenced. Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 31/12/2025 to the 31/03/2026.
EDoW	CRR24-16	Leadership	4 x 4= 16 ⟷	8	Reputational Seek 20-25	People & Culture Committee	Opened Dec 23. 10 actions identified, 4 completed, and 6 progressing Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 31/12/2025 to the 31/03/2026.
CDIO	CRR24-17	ICT Failure and Cyber	5 x 4 = 20 ⟷	15	Reputational Seek 20-25	Planning, Population Health & Partnership Committee	Opened Feb 24, 9 actions identified, 7 actions progressing with 3 revised due dates and 2 new actions identified. **Target score of 15 not in line with appetite.**.
EDoPH	CRR24-18	Operational Planning for Transmittable Diseases and Outbreaks	4 x 4= 16 ⟷	12	Quality Open 15-19	Planning, Population Health & Partnership Committee	Opened June 24. 7 actions identified, 5 actions progressing with 1 revised due date, 2 actions completed. Reduction in current risk score from 20 to 16 - November 2024, resulting in the risk now within the tolerance set within the risk appetite.
EDTSP	CRR24-19	Community Care Provision	4 x 5 = 20 ⟷	12	Quality 15-19	Quality, Safety and Experience Committee	Risk reviewed Jan 2025, 12 actions identified, 2 actions completed, with 3 actions progressing and 7 new actions identified. New risk developed by the services and approved by the Executive Director of Transformation and Strategic Planning. **Risk Score above tolerance set in risk appetite.**
EMD	CRR24-20		3 x 5 = 15	9	Quality	Quality, Safety and	Risk approved Nov 24, 7 actions in total, 3 completed actions, 4 progressing.

		Oncology Services	⟷		Open 15-19	Experience Committee	
COO	CRR24-21	Ophthalmology Services	4 x 5 = 20 ⟷	9	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-22	Orthodontic Services	4 x 4 = 16 ⟷	4	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 11 actions in total, 3 completed actions, 8 progressing.
COO	CRR24-23	Vascular Services	4 x 4 = 16 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 9 actions in total, 9 progressing.
COO	CRR24-24	Renal Services	4 x 4 = 16 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 3 actions in total, 3 progressing.
EMD	CRR23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 ⟷	9	Quality Open 5-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing.
EMD	CRR24-26	Urology Services	4 x 4 = 16 ⟷	6	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 3 progressing.

Appendix 2 – Corporate Risk Register as reported to Risk Scrutiny Group in January

CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/12/2024
Date Last Reviewed: 14/01/2025	**Director Lead:** Deputy Director of Workforce	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that BCU do not have a **highly skilled**, engaged and **motivated** workforce which could impact on safe delivery of care. This could be caused by **staffing shortfalls** organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.

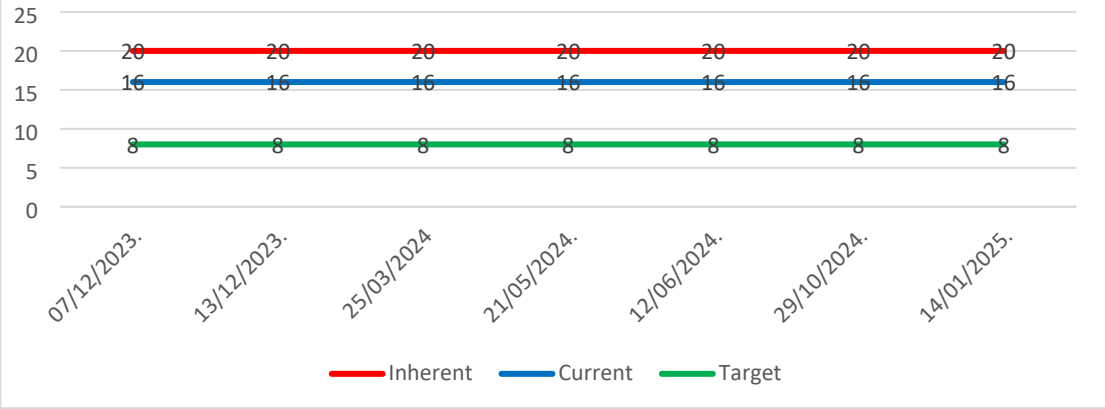
Mitigations/Controls in place	Additional Controls required
1. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 2. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 3. The Recruiting well and Joining Well programmes in place 4. Organisational Retention lead in post for BCU linked with national retention work through HEIW 5. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 6. New All Wales Flexible working policy has been ratified and is in place 7. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 8. Speak out Safely MDT in place 9. Work in Confidence platform for staff to safely raise concerns. 10. 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 11. The Culture Change Plan, which incorporated the results from the Staff Survey 12. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts 13. The key themes of the 2023 staff survey have been shared with the organisation 14. Approval of the new culture change and Behaviours Framework (ref CRR24-16) 15. International recruitment drives, both local and all Wales 16. People Managers Forums in place that include sessions on compassionate leadership and our values and behaviours framework	a) The programme of work through a new Education Governance Group to be established b) Implementation of the Employee Engagement plan and having a suite of clear indicators that measure employee engagement c) Development of a programme of work to ensure line manager's full involvement in employee engagement d) Feedback from the HEIW Nurse retention tool. e) Targeted management of sickness absence rates f) Engagement and operational effectiveness with Medical and Dental workforce g) an embedded workforce planning function

Actions	Due Date	Progression Analysis

REF Gaps in controls; A. Education and Learning Committee is being established as a control measure A Nursing specific educational and development group has been established. However, it has been identified that an Education Governance Group is required to oversee compliance and operational performance of Education. This is in development and a term of reference is expected to be ready by the end of October 2024 Work to setup the Education Governance Group is still ongoing however, the Terms of Reference and membership is still to be agreed. Due to unplanned absences in the People Service Leadership team this action has been extended	31/03/2025	Progressing (Revised date from 31/10/2024 then 31/12/2024)
REF Gaps in controls; B. NHS Staff Survey action plan to be developed and implemented across 24/25 There have been national delays to HBs receiving the survey data. As a result, the OD steering group have agreed the action plans will not be issued to IHCs at this stage, as not to overlap with the 2024 staff survey in October. Key themes from the 2023 survey have been issued to the organisation. This closed action has transferred to point 17 above in the mitigation section.	30/06/2024	Completed
REF Gaps in controls; B 2024 NHS Staff Survey has not closed with a 17.2% response rate. Quantitative data is due by end of January which will be distributed out to the organisational staff survey leads. This will inform actions to address issues and promote positive findings The qualitative data of the 2024 survey will be shared with the organisation when they are available, likely to be late spring 2025. An update will be provided in May.	30/05/2025	Progressing
REF Gaps in controls; C. Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed The findings from the Ararna report, which included a range of employee engagement methods, have been submitted to the CEO's office. These findings are being utilised in the Insights Report (formerly the Discovery Report) which will be shared with the organisation and Trade Unions, by the end of October, as part of determining the scope of and scale of any modifications to the HB operating model and structure. The results are referred to as the 'Insight Report' and are scheduled to be socialised with the Organisation during the end of October and November. The Discovery Report in FoTF has been presented to the Board and the Organisation, it has now moved into the design phase. A series of workshops with senior leaders will take place in Dec 24 and Jan 25. The outputs from the workshops will produce design options to be tested in the organisation prior to final option paper going to Board in May 2025	01/06/2025	Progressing (Revised date from 31/10/2024)
Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles. This completed action is transferred to point 14 above in the mitigation section	29/02/2024	Complete
REF Gaps in controls; B. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24 The world cafe took place as part of the leadership conference in June. The output from this, along with other staff engagement events, has contributed to the new Values and Behaviours framework which is currently being consulted on across the organisation and Trade Unions. It is planned that the Board will receive the framework in November 2024.	28/02/2025	Progressing (Revised date from 31/06/2024)

Following extensive engagement over 5 months the Board formally approved our refreshed values and behaviours framework in November 2024. There is a Communication & Socialisation plan in place and a high-level Embedding Plan in place was agreed by ET and P&CC. A more detailed version of the Embedding Plan will be provided to the CEO for approval. A Design Group is in place which supports the co-production and co-design of all work related to Culture Development.		
REF Gaps in controls; B, A toolkit on how to use the values and behaviours is in development	31/03/2025	Progressing
The Culture, Leadership & Engagement high level annual plan is in place for 2024/25. A subsequent plan for 2025/26 is in draft and will be finalised by March 2025	31/03/2025	Progressing
Ref Gaps in controls; E. A new risk specifically detailing actions to manage sickness absence, both physical and mental health related, has been drafted and will be ratified through POD leadership in January 2025.	28/02/2025	Progressing
Ref Gaps in controls; f. A Medical Staffing function will be re-introduced into the People Services directorate. Resource requirements will be identified in January/February with the intention to introduce the new function in Q1 2025/26	30/06/2025	Progressing
REF Gaps in controls; D. The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce. The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the **Staff Journey** programme of work. An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from Hire to Retire'. Work in being undertaken to identify gaps in each of the services with regards to policies and procedures. This will enable the Staff journey programme plan, which will include timescales, to be drafted. The draft illustrative map is under review and analysis of gaps in policy and process are being identified through a number of workstreams. The initial focus is on *Corporate and Local Induction*, *Shortlisting timescales*, *Advertising in recruitment* and the *Leaving Well booklet.* These initial workstreams are planned to be completed by the end of December 2024. The mapping work to identify development opportunities for our People (WP) policies and procedures is underway which informs the annual schedule led by the corporate governance team. Furthermore, an operational group is in place to review and update the corporate and local induction policy. Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025 a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment	31/12/2025	Progressing (Revised date from 31/12/2024)
REF Gaps in controls; G. A workforce planning lead was recruited earlier in 2024. A new Health Board approach to workforce planning is expected to be ratified in February 2025and will be submitted in the 2025/26 IMTP. The new approach contains a series of milestones that will improve workforce planning skills and knowledge across the organisation, improve guidance and resources for service leads and will incorporate a detailed workforce plan for the 2026/27 IMPT	31/03/2026	Progressing

		Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		15-19

Rationale for Corporate Risk

Staff engagement score at 72%, comparable with all Wales average of 73%. October 2024,
95% of wards consistently met staffing levels, supported by robust workforce planning and international recruitment initiatives. High turnover rates across certain key staff groups. vacancy rate improved during October, reducing by 0.5% to 7.8%. Turnover is on a steady downward trend, currently at 8% and down 0.7% in the last 12 months. lowest reported sickness absence levels across NHS Wales. Rolling sickness absence is largely reflective of the same period last year, 5.89% in October 2023 compared to 5.95% in October 2024. Stress, anxiety and depression continues as the highest reported reason despite also showing a reduction in time lost. Recruitment challenges and high reliance on agency staff have historically strained financial and operational performance.

CRR 24-02	**Risk Title:** Patient Safety		**Date Opened:** 02/07/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 30/12/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date**: 30/09/2025

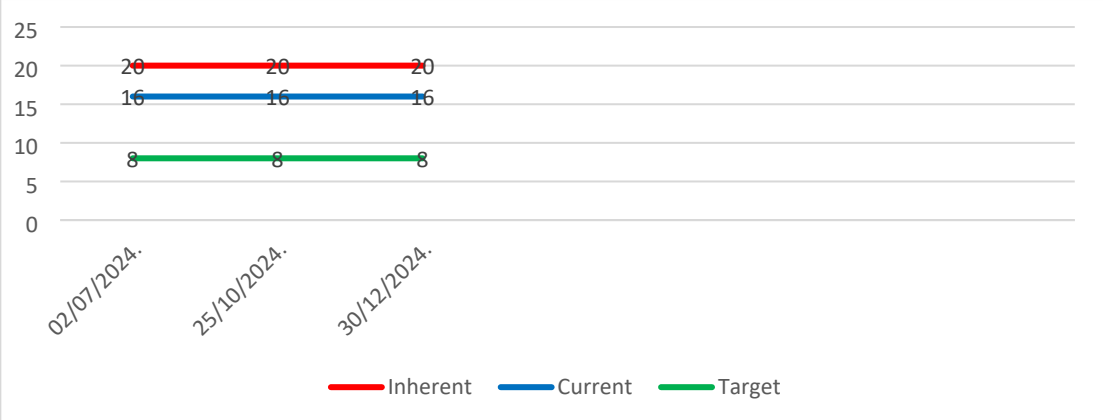
There is a risk that patients may experience preventable harm and a poor experience whilst receiving care due to inadequate preventative measures, not following correct procedures , adhering to best practice and/or learning from concerns . This could lead to poor quality of care resulting in severe complications, prolonged hospital stays, decreased quality of life, psychological distress, reputational damage, increased costs, and potential legal and financial consequences for the organisation.

Mitigations/Controls in place	Additional Controls required
1. Policies and Procedures to support risk assessment, guidance and escalation in place e.g.NU06 Prevention and Management of Adult Inpatient Falls, NU03 Pressure Ulcers, MM01 Medicines, National Early Warning Score. 2. Review of patient safety incidents at a local level supported by integrated concerns meetings and harms reviews for learning meetings. 3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Prevention and Management of Pressure Ulcers Group, Medicines Steering Group, Sepsis Triggers Escalation & Antibiotic Stewardship Review for learning and improvement. 4. Escalation to Quality Delivery Group and Quality, Safety and Experience Committee. 5. Cycle of business to PSG that includes IHC/Divisional deep dives of progress and action. 6. BCUHB wide Improvement plans for falls and HAPUs 7. Incident management process including rapid reviews, focused reviews and learning panels. 8. Staff induction, training and competency 9. Organisational Learning Forum for shared learning and improvement 10. Regular patient safety incident alerts issued to staff as and when required 11. Integrated concerns policy and framework implementation. 12. Bi-annual Nurse Staffing reviews are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing reviews are also	a. Sustained compliance of >85% of patient safety related mandatory training b. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review. c. Continue to undertake the bi-annual nurse staffing reviews to ensure we have the levels of staffing required to meet acuity as per NSA and clinical judgment

undertaken in other areas of the Health Board such as Community Hospitals, Mental Health, and other 24hr services.

13. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to enable roster performance to be actively managed. Additionally allocate Safe Care compliance reports are also sent to the Directors of Nursing, to enable maximum utilisation of nursing workforce.

Actions	Due Date	Progression Analysis
Workshops to be held across BCUHB to reduce backlog of open incidents using approved methodology to improve immediate learning. This includes setting of trajectories for improvement, cluster reviews and drop in clinics. This has been completed apart from within Central IHC, escalated and awaiting dates.	15/01/2025	Progressing (revised date from 30/09/2024)
Implement the Integrated concerns policy and framework to include toolkits for timely review of learning and action. Integrated concerns policy and framework has been implemented	31/08/2024	Complete
Strategy for Increasing compliance with mandatory training	31/01/2025	Progressing
Deliver all the actions from the Internal Audit of falls Combined HSE and Internal Audit action plan in place. Evidence is being compiled for action plan and submitted and reviewed at bi monthly to Falls Steering Group.	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite			

Rationale for Corporate Risk

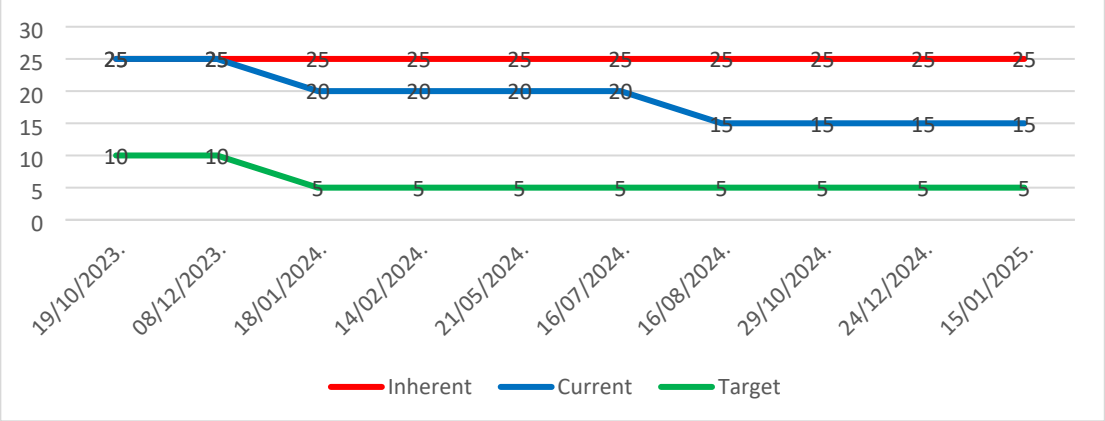
There are circa 38,000 patient safety incidents reported in the last financial year of which approximately 25% graded as moderate harm or above by the reporter. Feedback has also been received from His Majesty's Coroner in the form of regulation 28 prevention of future deaths around risks from timely investigation and implementation of actions to improve patient safety.

CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 15/01/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date:** 30/09/2025
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.			

Mitigations/Controls in place	Additional Controls required
1. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. Integrated Concerns Policy 2. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 3. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 4. Putting Things Right and clinical review processes and monitoring 5. Quality governance framework of meetings and reporting structured 6. Quality Dashboard and access to quality data from ward/team to Board 7. Patient and carer feedback and involvement processes 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. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 11. Organisational Learning Forum (OLF)**:** This forum promotes sharing of learning for continuous improvement and encourages sharing best practices and lessons learned to enhance safety and quality. 12. Exec Oversight Group**:** This group provides strategic direction and high-level oversight for risk management, ensuring alignment with organisational goals and adequate resource allocation. It also monitors and adjusts risk mitigation strategies.	a. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement (dashboard completed). b. Clarity on quality leadership, structures and accountabilities c. Development of a quality learning framework, aligned to the overall learning organisation programme d. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests e. Launch of a new Learning from Events (LEFR) process to improve divisional ownership and completion of a recovery plan to address the overdue position f. Medical engagement to ensure active participation and commitment from medical staff in learning and improvement. g. Integration of LFER/Claims – To enhance the management and resolution of claims, ensuring they are addressed promptly and effective h. Ensure learning from deaths – Provide the mortality panel with access to a process that ensures thematic learning from deaths is taken forward to facilitate continuous improvement.

13. Inquest Review Group: Focused on cases with significant adverse outcomes, this group conducts thorough investigations to recommend changes in policies and practices, ensuring accountability and transparency. 14. Rapid Review Process: Designed for urgent issues, this process uses streamlined methods to quickly identify risks and implement corrective actions, minimizing the impact of emerging risks. 15. New Thematic Review Group: This group conducts in-depth reviews of specific themes or patterns, developing targeted recommendations to address systemic issues and continuously improve the organisation.	

Actions	Due Date	Progression Analysis
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. Development work continues with a revised aim of March 2025. Work continues to develop the new Quality Learning Portal. Due to other work pressures, development on the Solution has slowed and little progress has been made since the previous update. These additional work pressures are being addressed, and the development continues on the admin app that will allow administrators to review learning prior to being published to the organisation. The first of three apps, which will allow users to enter learning into the system, is currently being tested. The second app is due to be completed by the end of December, with the final part of the Solution due to be complete early in the New Year. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB.	31/03/2025 – delayed due to DDAT priorities	Progressing (Date Revised from April 2024)
Delivery of improvement activity to reduce the overdue complaint, overdue investigation and overdue open incident position. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. NRI overdue position improved and all incidents overdue open on a positive downward trajectory - monitored weekly and through patient safety group	31/12/2024	Completed
Implementation of the new/approved QMS Framework within the identified pilot sites. Implementation of the QMS progressing in the test sites with other early adopters identified, this will be ongoing.	31/03/2025	New Action
Implementation of the new Learning from Events Report (LFER) process	31/01/2025	New Action
Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position	31/06/2025	New Action



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	Open		15-19

Rationale for Corporate Risk

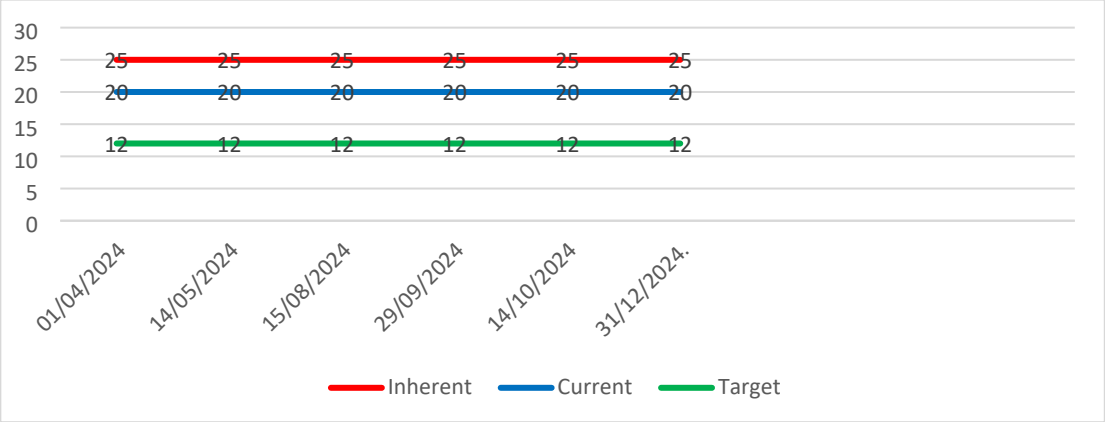
Learning is now being embed through Organisational Learning Forum (OLF) and the Integrated Concerns Forum (ICF), complaints and incidents position on a positive improvement trajectory. The monitoring of the sustained improvement is required prior to de-escalating the risk. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. Coroners have raised a number of common themes through these Regulation 28 reports, the quality of investigations and effectiveness of actions being the most common. The Health Board completed a Learning from Investigations Programme to assess and improve its investigation process and improve the assurances it can take on existing action plans. The programme had direct oversight from the Chief Executive and wider executive team and reported to the Quality, Safety and Experience Committee with a clear escalation process in place. The learning from this programme directly informed the new Integrated Concerns Policy which was approved by the Board in July and launched in September 2024 providing a new, integrated approach to patient safety investigations, complaint investigations and mortality reviews.

CRR 24-05	**Risk Title:** Delivery of the Annual Financial Plan		**Date Opened:** 01/04/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 23/12/2024
Date Last Reviewed: 31/12/24	**Director Lead:** Executive Director of Finance	**Link to BAF**:	**Target Risk Date:** 31/03/2025
There is a risk that the Health Board does not achieve the in year Financial Plan and Welsh Government control total (noting the key duty being to deliver break-even). Failure to achieve the financial plan could result in conditionally recurrent investment being withdrawn from the Health Board and central intervention to support attainment of the key financial duty in this or future financial years.			

Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Accountability Agreements issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board 3. Value and Sustainability programme approach to 2024/25 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts , moratorium on requests for Permanent recruitment to Band 8D and above (non clinical posts) and minimising interim staff appointments. 5. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 6. Financial reporting to Welsh Government on a monthly basis, with the Monthly Monitoring Return (MMR). 7. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent. 8. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements.	1. Welsh Government (WG) expectation to achieve financial balance, due to the financial settlement/allocations to Health Boards and to enter into financial stability. 2. The 24/25 Annual Plan and forecast financial outturn based on a level of expenditure controls and savings delivery that the Health Board considers to be sufficiently challenging and deliverable, whilst maintaining quality and patient care. 3. The Month 6 position showed a material deficit to date and therefore additional actions are required to control the run rate and recover the deficit above plan. These were endorsed for implementation through the Integrated Performance – Executive Delivery Group 4. Performance is reported and scrutinised through the IP – EDG monthly meetings where officers are held to account for delivery and bi-monthly within the Performance, Finance and Information Governance Committee and Health Board. 5. Escalation meetings where improvements are not realised are held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement.

9. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and regulations, and timely remediation of deficiencies.	

Actions	Due Date	Progression Analysis
Cease the run rate deterioration above plan and recover the year to deficit, to attain the forecast control total deficit for the financial year as agreed with Welsh Government. Via : Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Review of Corporate Controls and consider enhancing further. Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, with expenditure control totals issued for the remainder of the financial year.	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Financial		15-19

Rationale for Corporate Risk

M8 - Year to date position is reporting a deficit of £16.2m. This represents an £10.5m adverse variance compared to 6/12ths of the full year £19.7m planned deficit. The year to date deficit above plan is driven by Primary Prescribing, Continuing Health Care, Out of Area Mental Health placements and contracting pressures.

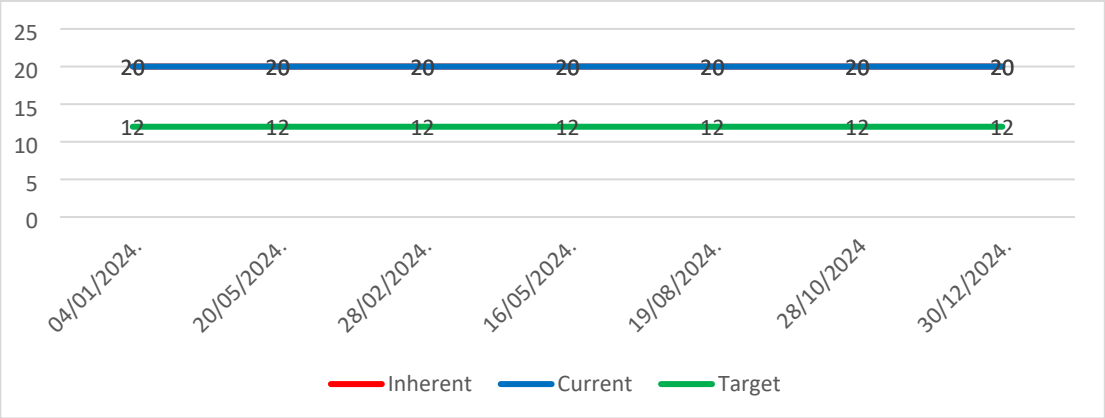
CRR 24-06	**Risk Title: Suitability and Safety of Sites**		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 23/12/2024
Date Last Reviewed: 30/12/2024	**Director Lead:** Executive Director of Finance	**Link to BAF**:	**Target Risk Date:** 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will submitted to Welsh Government – completion target date 2035).

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

Mitigations/Controls in place	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £12.448m for 24/25 approved by Welsh Government with an allocation of approximately £3.208m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: a) Fire Management b) Asbestos Management c) Water Safety, d) Ventilation Safety e) Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance	1. 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. 2. Assurance around the development control plan that it is aligned with both the Estates strategy and the Clinical strategy. 3. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team. 4. Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model. 5. Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. 6. Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented. 7. Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase 1. 8. Completion of applications for the Welsh Government (Capital, Estates & Facilities) Targeted Estates Fund for NHS Wales 2025-2027

10. Capital Allocation from Welsh Government – additional capital funding of £4.16M allocated to the Health Board to focus on Backlog Maintenance
11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.
12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.
13. Capital Funding from Welsh Government – additional capital funding of £2M allocated to the Health Board in year for slippage bids.

Actions	Due Date	Progression Analysis
Undertake action to deliver a Health Board Estates Rationalisation Programme Estates Rationalisation Programme being developed and in draft format. This will be finalised in conjunction with the new Director of Environment, once in post. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024	31/01/2025	Progressing
Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years. The 6 Facet survey contract is currently being procured through the SBS framework via mini-competition, the contract is due to be awarded by January 2025. A Phase 1 approach for the Acute Hospitals, is expected to be completed by 31/3/25. The completion of the full survey has been brought forward from the original 5 year time frame to a 2 year programme.	31/03/2026	Progressing
Review and update Development Control Plans	30/04/2025	Progressing
Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	31/3/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	4	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Current Risk score of 20 aims to be reduced to a 12 by April 2035. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog

N.B. Inherent and Current score lines stacked as both are 20.	costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog. The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board. To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2025. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025.

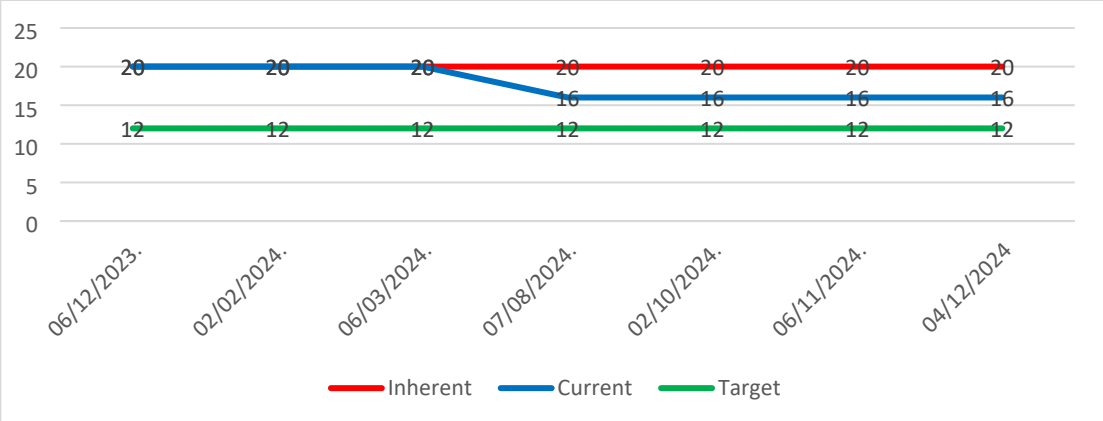
CRR 24-07	**Risk Title:** A Fragmented Patient Care Record		**Date Opened:** 06/12/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 10/12/2024
Date Last Reviewed: 04/12/2024	**Director Lead:** Chief Digital and Information Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2029
There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm.			

Mitigations/Controls in place	Additional Controls required
1. Current paper file identified as the Master Copy of the full record. 2. Access to current clinical systems to print clinical information ready to store in the Master File. 3. CITO Contract in place to house scanned document as a repository. 4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data. 5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place. 6. Dashboard in place which flags any new duplicate patient record created to allow immediate record merge. 7. Standard operating procedures involving searching for and storing patient information to prevent harm in cases where duplicate records exist is in place within Patient Administration System. 8. Optimisation Programme in place for the four main patient administration systems to review usage and reduce duplication across the systems. This will also support the removal of obsolete systems. 9. Assistant Director of Patient Records now member of Clinical Effectiveness Group and Patient Safety and Quality Group to ensure harms associated with patient records are addressed. 10. The work underway with the Mental Health Electronic Health Record Programme is the first part of the future Electronic Health Record journey with the governance route agreed.	a. Lack of current system capabilities to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on EPOC, EPRO and WCP to review current systems interoperability and functionality. CITO has been agreed as the Electronic Document Management System for the Health Record. b. Availability of current paper records within digital environment. The Electronic Health Record outline business case will analyse resource requirements to consider scanning or dual processing of records. Scanning Strategy currently in development. c. Standard practice registration across the three acute sites. Proposal developed including resource funding required based on the East Health Records service coverage. Awaiting outcome of the cost pressure resource allocation. d. No agreement to fund additional Health Records staff to address backlog of duplicate patient records / identifiers. Standardised procedures in place to prevent re-occurrence. e. The Clinical Design Authority is being established first meeting 1st December 2024 to ensure that the design and use of digital systems does not compromise the safety, quality, or effectiveness of care, and that it enhances the patient experience and outcomes. f. Lack of quality within the content of current patient records. Office of the Medical Director accepted ownership and will consider as part of professional standards.

	g. Continued delay in confirmation of membership at the Patient Safety and Quality Group. Progress chasing monthly in place. h. Correct use of current clinical systems. Current review underway to establish usage with a future plan including training on the use and capability of all systems.

Actions	Due Date	Progression Analysis
Establish the cost and resource requirements to back scan all live records Third Party secured to support the development of the Scanning Strategy. Action due date extended to allow completion of report.	31/03/2025	Progressing (revised date from 31/01/2025)
Develop a Health Board Scanning Strategy Third Party secured and work will commence on the 9th December 2024 to develop the Scanning Strategy.	31/03/2025	Progressing
Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams Training Strategy currently in draft and will be approved at the DDaT Senior Leadership Team meeting in January 2025.	31/03/2025	Progressing
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record Identified current systems which can be decommissioned as part of the EHR implementation.	30/04/2025	Progressing
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project)	30/04/2025	Progressing
Recruitment of additional health records staff to standardise the registration practice across three acute sites. Additional funding secured to standardise process across the three sites which will contribute towards mitigating the duplicate patient registration by providing 24/7 365 days service across the Acute Patient Records Service. Action due date extended to allow time to recruit and train to posts.	31/05/2025	Progressing (revised date from 31/11/2024)
Engage with the Estates Rationalisation Programme to secure the future of "fit for purpose" file libraries for legacy paper records. Meeting held with Corporate Risk Lead to establish a joint stakeholder input to manage the risk. No further input or contact with Estates has been possible specifically around the Ysbyty Glan Clwyd File Library..	30/06/2025	New action

Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Planning, Population Health and Partnerships Committee. West Community baseline assessment completed with follow up report being presented to the IHC in January 2025. Further plans in place to conduct East and Centre community sites before work commences on the acute sites.	31/08/2025	New action



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

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

CRR 24-08	**Risk Title:** Delivering a population health approach to health and wellbeing		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee (PPPH)		**Date Last Committee Review:** 10/12/2024
Date Last Reviewed: 12/12/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/03/2025

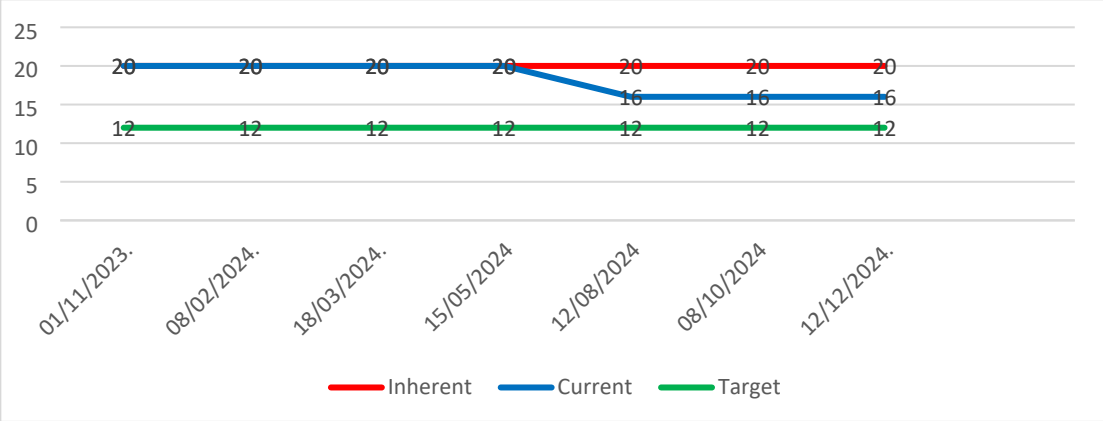
There is a risk that the Health Board fails to consider and implement prevention and early intervention models in order to reduce health inequalities and improve long term population health and wellbeing. This may be caused by a lack of prioritisation, planning and delivery in relation to the prevention of ill health and early intervention.
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 to increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

Mitigations/Controls in place	Additional Controls required
1. Population Health Executive Delivery Group provides strategic direction ensuring alignment with health priorities and effectively mitigating the risk of misalignment or lack of focus in population health initiatives 2. Annual development of IHC data packs and headline report support Health Board planning to reflect current and emerging need. 3. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise and guidance. 4. Funding associated with Healthy Weight Healthy Wales which was formerly non-recurrent grants has now been added recurrently to the Health Board core budget. 5. Prevention and health inequalities form key part of the Health Board Integrated plan 24-27, ensuring that these critical areas are prioritised and integrated into strategic initiatives to mitigate the risk of neglecting health equity and prevention efforts 6. Interviews have taken place for 2 x vacant Consultant in Public Health posts and appointed to, ensuring the team is adequately staffed to maintain effective public health management and mitigate the risk of gaps in expertise	a. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand. Understanding our current prevention offer as a health board, its impact and our population needs used in conjunction with clinical data will inform development of the prevention offer and approaches. b. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. Prevention activities at scale which create an impact requires long term, sustainable and growth investment. c. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available. Recognising which data is important and where there are gaps in the data will allow more effective and targeted planning. d. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.

7. Board Awareness session regarding the 'shift to Prevention' focus has taken place in July 24 to ensure leadership is aligned with strategic priorities and mitigating the risk of insufficient understanding or support for the prevention agenda 8. DDAT and Public Health Team are meeting to progress data requirements and address gaps ensuring data integrity and supporting informed decision making to mitigate risks of incomplete or inaccurate data and to align clinical and population health data which supports informed decision making. 9. Quarter 1 Prevention deliverables within the Health Board Plan 24/25-26/27 have been achieved. 10. Receipt of the evaluation report for the Inverse Care Law activity. The Inverse Care Law activity report will provide insights to address any gaps and inform future actions, thereby contributing to reducing the risk of the inverse care law - The inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served 11. Review / refresh of IHC Data packs to inform planning ensuring that up to date and accurate data is used to mitigate the risk of outdated or incomplete information influencing decision-making and support prioritisation of prevention based plans 12. Population Health Executive Delivery Group – Workshop 'Prevention – Priorities, Planning and Delivery' to inform direction and planning has taken place. 13. Quarter 2 Prevention deliverables in the Health Board Plan 24/25-26/27 have been achieved. 14. Well North Wales Paper received by Board, outlining the direction for this integral programme approved (Oct 24). This provides a framework for change which supports the reduction of health inequalities in collaboration with partners. 15. Strategic Arts in Health Plan received by Board, approved (Oct 24). This provides clear direction together with partners to support health and wellbeing through the use of arts. 16. PPHP Committee received delivery update by Health Protection Team (Aug 24).	The appointment process for the Executive Director of Public Health needs to be finalised e. Prevention and early intervention actions and deliverables embedded within service and IHC plans and monitored routinely as part of performance monitoring Prevention is a priority theme which runs through the draft Health Board 3 year plan 25-28 however the IHC plans have not yet been reviewed. f. Staff training – Make Every Contact Count this recognises that all staff can take opportunity to use key day to day interactions to open up discussions about improving health and wellbeing and support positive changes

Actions	Due Date	Progression Analysis
Recruitment to vacant Senior Practitioner posts. Appointments made, commencing January/February 2025	31/11/2024	Completed
IHC Plans (as part of the Health Board 3 year plan) 25/26-27/28 evidence response to the IHC Population Health data packs and deliverables. BCU Planning Framework has now been approved. The BCUHB draft 3 year plan December 2024 acknowledges Prevention as a key theme. MECC (Make Every Contact Count) training for staff is identified as an area for consideration in IHC Plans. Unable to close this action until IHC Plans have been reviewed	31/03/2025	Progressing (revised date from 30/11/2024
Recruitment to the post of Executive Director of Public Health. Interviews are completed. Awaiting completion of the appointment administrative process.	01/02/2025	Progressing (revised date from 31/12/2024)
A review of the impact of specific preventative services has commenced. This action will continue into 25/26. It is anticipated it will form part of the Health Board Delivery plan 25/26-27/28. A review of Weight Management Services has been agreed.	31/03/2025	Progressing
Health Board Annual Plan / 3 year milestones and associated activity. The Health Board plan approved for 24-27 reflects prevention priorities and deliverables. BCU Planning Framework has now been approved. Draft BCUHB Plan December 2024 evidences Prevention as a key cross cutting theme.	31/03/2025	Progressing
Executive Director of Public Health will agree the Prevention Priorities and Prevention Deliverables as part of the BCUHB Plan development 25-28, as the identified Executive lead – which contribute to delivery of the Health Board 5 Strategic Objectives. Draft deliverables have been submitted and approved by the Executive Director of Public Health.	31/03/2025	progressing
The Public Health Team will carry out a review of existing programmes of work and agree Directorate priorities 25/26 Programmes of work have been agreed and included in the health board plan 25-28. Supporting infrastructure is now being developed to ensure delivery.	31/03/2025	Progressing

Programme plans developed for Health Protection, Health Improvement, Health Inequalities and Healthcare Public Health which contribute to the additional controls required	31/03/2025	New Action



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

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

CRR 24-09	**Risk Title:** Primary Care		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 06/01/2025	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

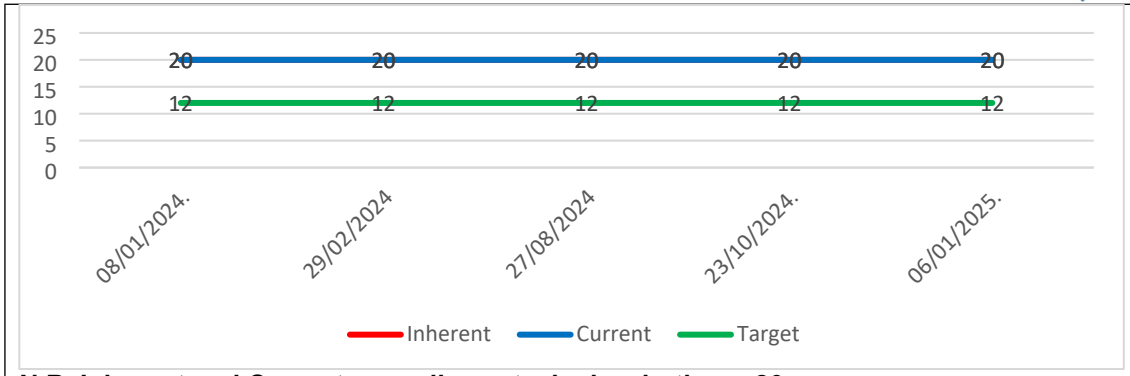
There is a risk that the Health Board's ability to meet its statutory obligation to provide primary care services will be impacted by growing patient demand, workforce and financial pressures. This could be caused by financial pressures due to factors such as rising operational costs and insufficient funding. This could lead to ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

Mitigations/Controls in place	Additional Controls required
1. Primary Care Board established in 2024 to ensure executive oversight of services. 2. Primary Care sub groups established in 2024 that focus on specific key elements of service overview including governance and quality, workforce and contracting. 3. Primary care team working closely with national team to deliver Strategic Programme for Primary Care (SPPC) in North Wales Focuses on elements including Accelerated Cluster Development, Pan-Cluster Planning Groups, Primary Care Professional collaboratives and the Primary Care Academies. 4. Established Cluster and Collaborative Leads across the 14 cluster areas in BCU. 5. Pan Cluster Planning Groups (PCPGs) are now in place across each IHC in the Health Board, and are supported by the Local Authorities and Public Health.	a. Primary care plan needed to set out long term strategy for services b. Programme management approach needed to monitor and drive strategic and operational priorities. c. Consistent approach to managing primary care services across BCU is needed. Currently most services are managed at an IHC level. d. A clear governance framework is needed for each primary care service that will ultimately feed into the Primary Care Board. This will allow risk and other areas of assurance to be discussed and monitored. e. Developing stronger working relationships with internal and external stakeholders in order to optimise the management of services and patient flow in the wider system

Actions	Due Date	Progression Analysis
Primary Care strategic plan	31/03/2025	Progressing

A plan needs to be created that looks at all areas of primary care, and describes what the long term strategy is and how it will be delivered.		
Implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care Academy to utilise SPPC monies to further progress multi-professional working Work on going to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC. Update expected nationally in November 2024.	31/03/2025	Progressing (revised date from 31/12/2024)
a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery	31/03/2025	Progressing (revised date from 31/12/2024)
Primary Care plan/strategy drafted to lay ground work for pathway to true Partnership and integrated working, with joint planning and decision making across Local Authorities/NHS for health, care and prevention.	31/03/2025	Progressing
Place based person centred provision to be at the forefront of planning, transformation and innovation in all health and social care plans.	31/03/2026	Progressing
Deep dive / diagnostic into general dental and community dental services (scope to be defined)	31/03/2025	Progressing

	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	Quality		15-19

Rationale for Corporate Risk

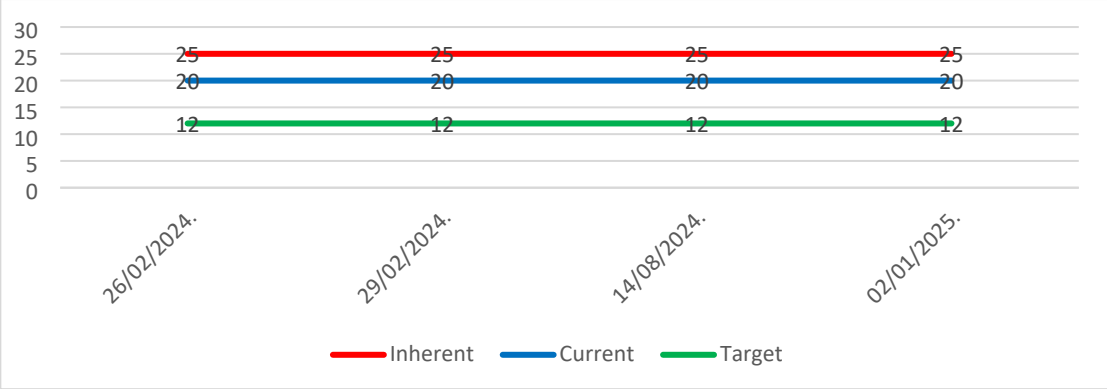
This risk sits across all primary care services within BCU. The risk of having an ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

CRR 24-10	**Risk Title:** Urgent and Emergency Care		**Date Opened:** 26/02/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 23/12/2024
Date Last Reviewed: 02/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 30/03/2025

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

Mitigations/Controls in place	Additional Controls required
1. System resilience hub introduced in December to ensure consistent approach to daily resilience calls BCUHB wide focused on prevention of and mitigating actions in response to reducing delays already in the system. Hospital full protocols reviewed and updated to support rapid de-escalation during peak periods of demand. Winter resilience plan, and festive period plans, developed to manage whole system pressures. 2. Ambulance handover guidance shared and utilised as part of the system resilience calls. Ambulance escalation process to support peak periods of demand. 3. UEC programme governance and reporting structure realigned into 4 workstreams (brings together all relevant improvement projects into a single improvement programme). 4. Workstream 1 focused on the community wrap around care ensuring that care, wherever safe to do so, is delivered closer or at home to avoid unnecessary conveyance and admission. 5. Single Integrated Clinical Advice Triage (SICAT) and GPOOHs services working together to provide 24/7 model across North Wales. Health Care Professional line available alongside review of the ambulance stack to avoid long waits. 6. 0800-2000hrs funded GP service working alongside WAST/111 to reduce ambulance responses and manage patients through alternative pathways reducing the need for ambulance attendances 7. Workstream 2 focused on providing direct access to services as a safe alternatives to Emergency Departments (EDs) 8. EDs working to the All-Wales ED quality statement; Same Day Emergency Care (SDEC) services at all acute sites for those emergency admissions that would have had an overnight stay to be managed and discharged home the same day. Direct access to SDEC is available to health care professionals including Primary Care, 111 and WAST. 9. Red Cross ED Wellbeing and Home Safe service provided across all EDs to support patients during their time within EDs and provide a safe discharge solution and settlement safe avoiding reattendance /readmission. 10. Workstream 3 in place improving patient flow and therefore reducing overcrowding in EDs and subsequent ambulance handover delays at the front door 11. Optimal Hospital Flow framework supported by daily board rounds to ensure every day is a green or value added day for the individual thereby avoiding delays in the patient pathway and reducing the time spent in hospital and deconditioning. 12. Regular reviews of long stay patients in acute & community hospitals to reduce average length of stay. 13. Workstream 4 in place (continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos). 14. Review of Complex Care arrangements in place to improve system improvements and to reduce delays, managed each IHC's Clinically optimised weekly meetings. 15. Adverse discharge meetings in place as real time feedback, ensure lessons learnt and build trust across organisations. 16. Trusted Assessors (in 4 areas) reducing time for assessment.	a) A number of key roles within the UEC Improvement Programme remain as temporary / secondments and this will impact on the inability to drive the required system change. b) Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds. c) Funding spot purchasing of beds to assist with stepping up of patient care rather than hospital admissions and step down for assessment of individuals needs in a community setting. Implementation plans being agreed through additional 50 day challenge funding provided December 2024. d) Trusted assessors development, ongoing work for the last 18 months, support required to progress at pace. e) Continuous flow modelling – National presentation on a model to decompress the Emergency department and create movement to reduce delays. f) Get it Right First Time (GIRFT)/SEDIT reports to support demand management across North Wales need to be implemented through workstream 1 delivered by IHC operational teams

Actions	Due Date	Progression Analysis
Health board to support development of a pan North Wales UEC (SICAT remodelling) hub prior to Winter 2024 to ensure 24/7 service support, in conjunction with national support and forthcoming escalation triggers. The process of review is in place and will be led by workstream 1 of UEC programme.	31/03/2025	In progress (date revised from 15/01/2025)
BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 2024- WXH IHC have been the site supported by Executives as initial trial site. Ongoing assurance discussions with East IHC and Swansea Bay continue in light of concerns raised. Final meeting planned for end of June 2024. This action has now been re-instated by the Interim COO and agreement of time scales for implementation.	31/03/2025	In progress (was delayed, date revised from 30/06/2024)
Workstream plans being developed (some controls in place) and agreed with each lead, plans are pan North Wales with operational delivery through each of the IHCs. Workstream plans are aligned to the annual plan and the 3 ministerial priorities for 2024/25. Workstreams focused on key areas within the patient pathway will work with partners across the UEC whole system to deliver the necessary improvement; 1. Support at the individual's front door 2. Hospital front door 3. Hospital flow 4. Discharge from hospital	31/3/2025	In progress
Review of all outstanding audit, GIRFT and HIW reports to ensure that actions plans are captured and any outstanding actions delivered within the relevant workstreams and lessons learnt used to inform sustained improvement	31/3/2025	In progress
Annual plan narrative for 25/26 delivery drafted, awaiting planning guidance for 25/26, dues 23rd December 2024, to ensure that annual plan for UEC and subsequent workstream plans are aligned to the ministerial priorities for 25/26 and the de-escalation framework.	31/3/2025	In progress



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Open		15-19

Rationale for Corporate Risk

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years

	and other NHS Wales bodies. 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the Welsh Ambulance Service. Goal to be in line with WG targets.

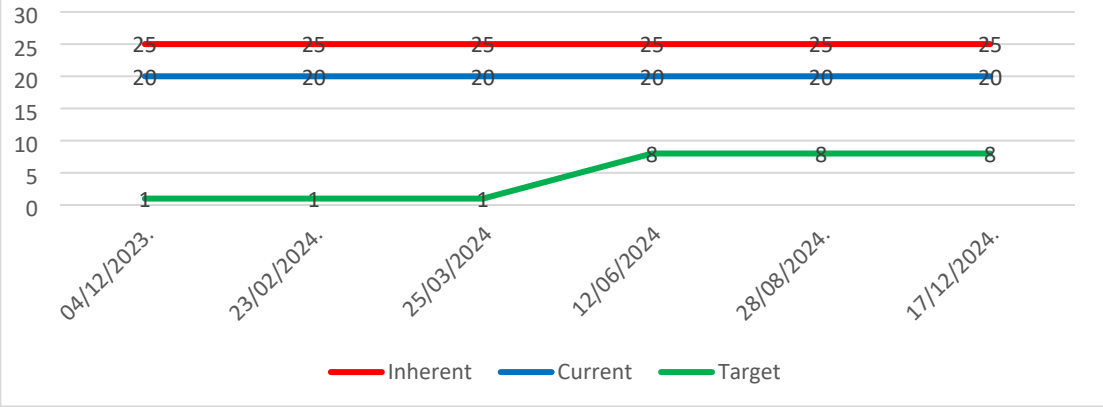
CRR 24-11	**Risk Title:** Planned Care		**Date Opened:** 04/12/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 23/12/2024
Date Last Reviewed: 17/12/2024	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/2025 (interim review)

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

Mitigations/Controls in place	Additional Controls required
1. Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer > Urgent > Routine) 2. Performance monitored via weekly corporate access meeting and locally via IHC weekly access meetings including long waits and clinical prioritisation. 3. Clinical prioritisation and review of waiting lists ongoing. 4. Validating waiting list cohorts. 5. Joint Patient Admin and Booking Centre. 6. Leadership, Chief Operating Officer now recruited for both interim and substantive.	1. Need a substantial in sourcing/outsourcing commissioning piece of work over a longer timeframe 2-3 years 2. Capacity and demand modelling and trajectory tracking 3. Clinically led development of sustainable service models to secure long term safe quality provision 4. Implementation of GiRFT and wider recommendations from service review processes (including from Clinical Implementation networks nationally) 5. Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access). 6. The planned care funds require quicker mobilisation in future years 7. Refresh and renew INNU policy to ensure referrals are appropriate. 8. Demand and capacity plan (in progress) completed to inform specialty level position for 2025/26 and targeted support where shortfalls identified

Actions	**Due Date**	**Progression Analysis**
Recruiting clinical leads and project management capacity to support clinically led specialty programmes of work in order to secure successful design and delivery of sustainable models of care	31.03.25	In progress
Procurement for insourcing for endoscopy and diagnostics Insourcing endoscopy business case approval at Executive Team	01/11/2024	Completed
Ensure completion of demand and capacity analysis to inform forward looking activity and produce mitigations for shortfalls	31/03/25	Progressing
Minimise escalation into elective capacity through UEC improvement programme	31/01/2025	Progressing
Plan substantially increased additional capacity delivery for onboarding early in the new financial year.	31/03/2025	Not started – requires approval of scope

		Impact	Likelihood	Score



Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	Open		15-19

Rationale for Corporate Risk

RTT 52 week waits stage one - NHS Wales Performance Framework 2024-25 Target = 0. Current positions RTT >52 Stage 1 – 27,880 (unbooked)

RTT 104 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0. Current positions RTT 104 all Stages -11,993 (9,706 over 104w +1,198 over 156w + 10 over 208w – unbooked position) To achieve this within 12 months would mean in the order of an additional 2,417 cases per month, at least 1,459 of which would be stage ones.

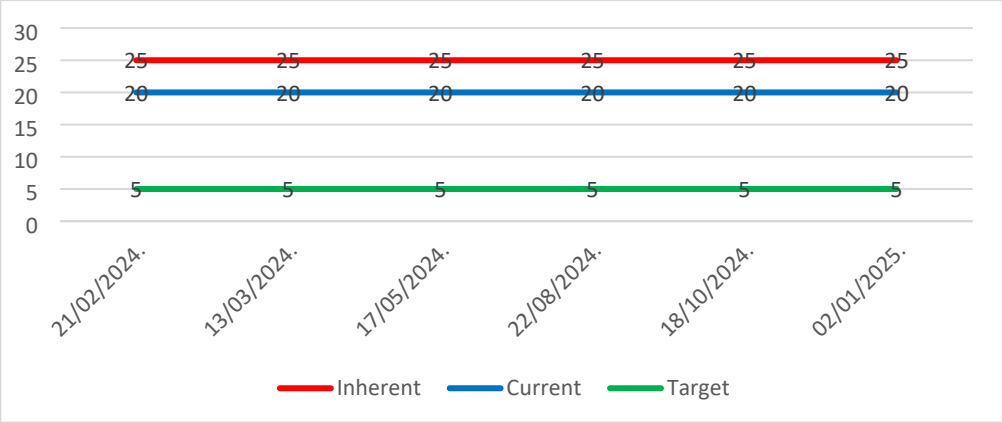
RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to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

CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 02/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/2025

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

Mitigations/Controls in place	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Significant guidance and steer with National Imaging Programme workforce work. 3. Outsourcing of radiology reporting to maintain Welsh government turnaround times 4. Waiting list & capacity and demand management is in place to monitor radiology required resources. 5. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting 6. Active participation by pathology in the nation pathology programme	a. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for 19th May 2025 b. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally c. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements d. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director. Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 e. PHW Collaborative Executive group. f. Diagnostic Strategy for BCU needs to be developed g. Mitigation of the risk of failure to act. h. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025.	14/04/2025	Progressing
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/06/2025	Progressing (Revised date from 30/09/2024)
Escalate failure to act risks to CEG	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Increasing demand for both radiology and pathology and other diagnostic services. Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues. Additional work required to mitigate the risks from failure to act and update procedure MD23. Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024. Demand in radiology continues to increase.
MDT demand in terms of numbers of patients on an MDT is at unsafe levels.
Workforce and organisation development have escalated risks within DSCSS

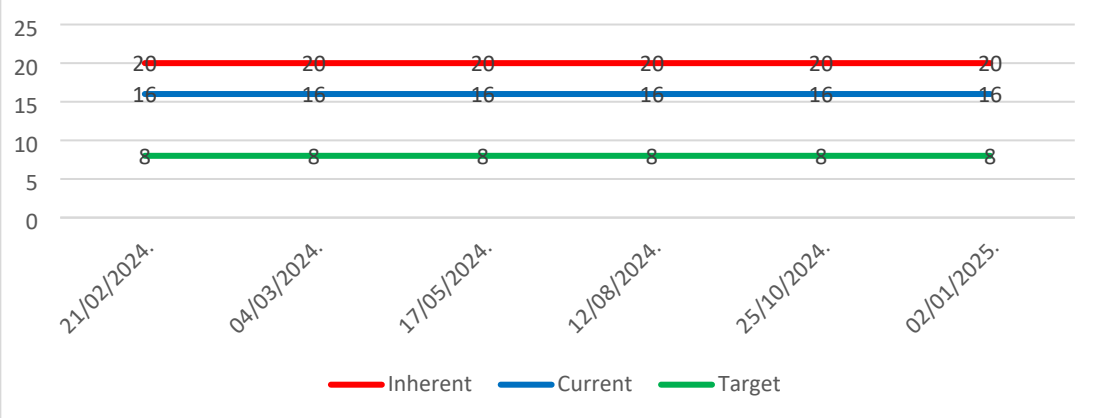
	about the health and wellbeing of the radiology senior team due to the number of competing priorities and the unsustainable amount of TOIL being accrued and unable to be taken by radiology SMT to manage the higher number of major projects and the operational delivery

CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 02/01/2025	**Director Lead:** Executive Director of Allied Health Professions & Health Science	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025
There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.			

Mitigations/Controls in place	Additional Controls required
1. Medical Devices Governance and Assurance Group leads on selection and procurement, processes and procedures of significance, learning from incidents, safety communications and risk management of medical devices. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on affected equipment in line with regulatory compliance completed. 8. Radiology fully engaged with the National Imaging Capital Equipment Group peer review programme.	a. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. b. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016. c. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement. d. The number of capital bids not approved now exceeding circa £30million in capital and resources required. Backlog of equipment beyond end of life, some 10 years+. SBAR submitted to EDAHPHS for escalation to Executive team. e. Medical Device regulations work ongoing – see additional risk ID 5282 ‘Medical Devices Regulations 2002(SI 2002 No 618, as amended) (UK MDR 2002) compliance’. External review completed. Workplan now needs to be considered.

9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking.	

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2025	Progressing (Revised from 31/03/2024)
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance Medical Physics are working through the ultrasound Quality Assurance and testing.	31/03/2025	Progressing (Revised from 31/09/2024)
Directorate teams to review their medical devices capital replacement plans to ensure all services have a medical device replacement programme in place. Directorate teams are linking with Capital to update their replacement plans.	31/03/2025	Progressing (Revised from 31/09/2024)
Recruitment to Head of Clinical Engineering and associated posts within the medical devices team Recruitment to Head of Clinical Engineering is progressing, currently with Welsh translation and approval by Exec Director of Operations.	31/03/2025	Progressing (Revised from 31/09/2024)



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		15-19

Rationale for Corporate Risk

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

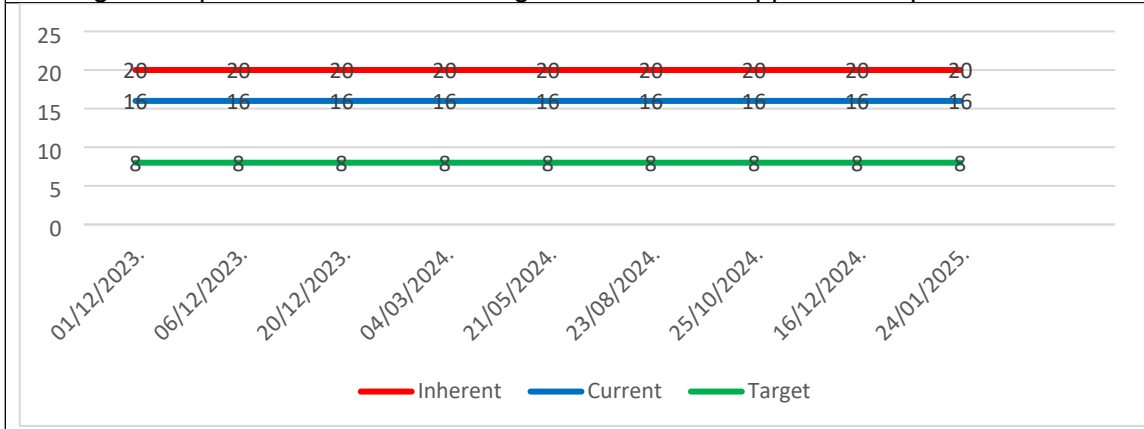
CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/12/2024
Date Last Reviewed: 24/01/2025	**Director Lead:** Deputy Director of People	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

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

Mitigations/Controls in place	Additional Controls required
1. Three-year Occupational Health, Safety and Security strategy. 2. Health and Safety Policies report into the Strategic Occupational Health & Safety Group. 3. Health and Safety eLearning and short courses in place. 4. Gap Analysis has been reviewed. Strategy and plan to March 2026. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly.	a. NHS Employer Health and Safety Standards are being developed b. A review of resources required following the internal audit. c. BCUHB Executive Team and Board of Directors to complete health and safety training. d. The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed e. Investment in training venues is required for manual handling training delivery. f. Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training.. g. Review of health and safety policies within the next 12-24 months. h. A Health and Safety Risk Assessment and Management Framework needs developing. i. A pan BCUHB Health, Safety and Security Training Needs Analysis is required. j. Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. k. Intranet pages for Health, Safety and Security Services require development.

Actions	Due Date	Progression Analysis
A new approach is required supplemented by a clear strategy and framework.	31/12/2025	Progressing (Revised date from 31/12/2024)

The Health and Safety Policies and procedures require a review. Compliance spreadsheet to be included in the SOSHG Agenda going forward.	31/03/2025	Progressing
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off.	31/03/2025	Progressing (Revised date from 31/12/2024)
Health and Safety training to be arranged for the Board. Training date set for 27/02/2025.	31/03/2025	Progressing (Revised date from 31/12/2024)
Updated strategy and plan developed with key service objectives identified to March 2026.	31/12/2025	Progressing (Revised date from 31/12/2024)
A process to monitor and review department self-assessments is needed.	31/12/2025	Progressing (Revised date from 31/12/2024)
A review of resources within the Health, Safety and Security Service is required following the internal audit findings.22/01/2025: Structure reviewed and remodelled. A business case to be developed.	31/03/2025	Progressing
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed.	31/03/2025	Progressing
A Health and Safety Risk Assessment and Management Framework is needed. Work to commence FY 2025/26	31/03/2026	Not Started
An electronic document management system (EDMS) for reporting of health and safety compliance and risk management pan BCUHB. Risk Management software approved. Implementation 2026	01/01/2027	Not Started



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory		20-25

Rationale for Corporate Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to

	loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

CRR 24-16	**Risk Title:** Leadership		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 12/12/2024
Date Last Reviewed: 14/01/2025	**Director Lead:** Deputy Director of Workforce	**Link to BAF**:	**Target Risk Date:** 31/03/2026

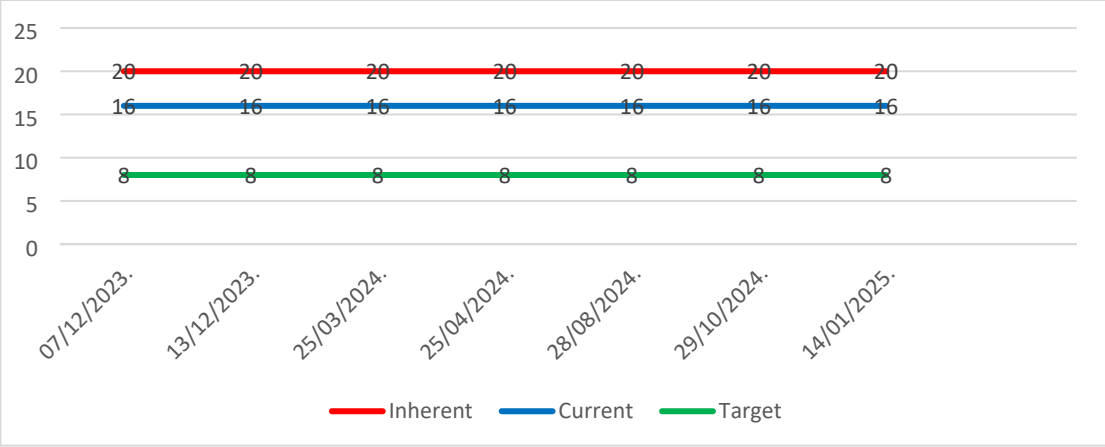
There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance 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.

Mitigations/Controls in place	Additional Controls required
1. Integrated Leadership Development Framework (ILDF) 2. Culture change and Behaviours Framework. 3. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. Three conferences have been held so far with over 750 attendees 4. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 5. Full Board now in place and all committees now chaired and attended by full complement of Independent Members 6. Culture change agents in place across the organisation 7. The Board formally signed the NHS Wales' Compassionate Leadership Pledge in September 2024. 8. A compassionate behaviour resources, video co-produced with HEIW. 9. Compassionate leadership modules are now integrated into all leadership and management development programmes. 10. An approved Culture Leadership and Development Plan	a. Further embedding of Integrated Leadership Development Framework. b. Implementation and measurement of compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours c. Formal Culture Change Plan and accompanying Comms and Engagement plan d. A Behaviours Framework (will be derived from the culture change workstream) e. Appropriately resourced Culture Change programme and realignment of resources within the OD function. f. Filling of gaps in Executive team

Actions	Due Date	Progression Analysis

REF Gaps in controls; A & B. Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) • The lower level programmes within the ILDF have commenced. Mynydd Mawr – Foundations of Leadership and Management Programme - commenced it's first cohort on the 27th June 2024. A further 16 cohorts are scheduled through to March 2025 • The OD function is undergoing a re-alignment of resources to be in place by the end of December 2024 this will support the delivery of the ILDF action plan from September/October onwards. The Advanced Clinical Leadership Programme (ACLP) is currently in progress with 26 BCUHB clinical leaders engaged on the programme. This is a well-established programme developed by HEIW to support and develop senior clinical leaders. The programme commenced in February 2024 and is due to complete at the end of the year. • A new Leadership hub, hosted on Gwella, will be launched in November 2024 which incorporates online resources for our current and aspirational leaders. Alongside this a People Managers Forum will also be launched. The People Managers Forum will be a space for all people managers to network and share their experience and will be hosted virtually in the first instance. The forum will support our people managers in developing their skills and competence, help them keep up to date with recent changes in policies and processes and aims to build a community of practice that is an engaging and supportive space.	31/12/2024	Complete
REF Gaps in controls; A, Define the indicators (quantitative and qualitative) that will enable the organisation to measure the on-going effectiveness of the ILDF.	31/03/2025	Progressing
REF Gaps in controls; A, The ILDF courses and development resources for mid-level management/leadership will be designed and implemented across 2025/26	31/03/2026	Progressing
REF Gaps in controls; A, B, D, A suite of masterclasses and workshops will be launched in Q1 2025/26 which are aimed to give wrap-around support to our leaders across the organisation.	30/06/2025	Progressing
REF Gaps in controls; C & D. A draft OD plan in development (forms part of special measures monitoring) and has been initially approved by the culture steering group. The next steps are to ratify the plan with the senior team and People & Culture Steering Group The OD plan is under consultation and is expected to be ratified by Board in November 2024 The Culture Leadership & Engagement plan has been approved and is now in place. Reference point 10 in the mitigation section	30/11/2024	Complete
REF Gaps in controls; C& E. 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 The Leadership Conference (inc. the world cafe) took place in June to assess the culture, values and behaviours of the organisation. The results, along with a range of related reviews and staff engagement mechanisms, informed the new Culture change programme and Behaviours Framework. This closed action is transferred to point 7 in the 'controls in place' section.	31/08/2024	Completed
REF Gaps in controls; B & C, A further Leadership conference will be held in Q1; the topic and content is currently being ratified and will be confirmed by March 2025	31/03/2025	Progressing

REF Gaps in controls; E, Alignment of OD resource is still underway. The permanent structure is in place but a number of the non-recurrent posts remain vacant with ongoing discussion regarding funding. It is hoped to have the posts filled by Q1 2025/26	30/06/2025	Progressing
REF Gaps in controls; B,C, D & E. Further embedding of compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours. Formal Culture Change Plan and accompanying Comms and Engagement plan. A Behaviours Framework (will be derived from the culture change workstream). An appropriately resourced Culture Change programme and realignment of resources within the OD function. This action is now closed as the remaining workstreams are detailed in CRR24-01.	31/12/2024	Completed (refer to CRR24-01)
Whilst it is not unusual to have a vacant Executive position, there are a small number of posts that have not been filled substantively for some time which may impact the overall scoring of this risk; Executive Director of People & OD – Interview TBC Executive Director of Finance – Interview Jan 25 Executive Medical Director – Interview Feb/Mar 25	30/05/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Reputational		20-25

Rationale for Corporate Risk

Staff retention is 90.5% compared to 90.3% last year. PADR compliance showed improvement in October 2024, following a period of reducing rates, increasing by 0.7% to 77.8%. The Grievance trend of cases have is rising but the number of new cases has dropped in the previous 2 months. The percentage of stress & anxiety absences remains high at 1.8%. Avoidable turnover has dropped from 5.9% to 4.8% compared to January 2023.

CRR24-18	**Risk Title:** Operational Planning for Transmittable Diseases and Outbreaks - Health Protection		**Date Opened:** 03/04/2024
	Assuring Committee: Planning, Population Health and Partnerships Committee		**Date Last Committee Review:** 20/12/2024
Date Last Reviewed: 29/11/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/01/2025

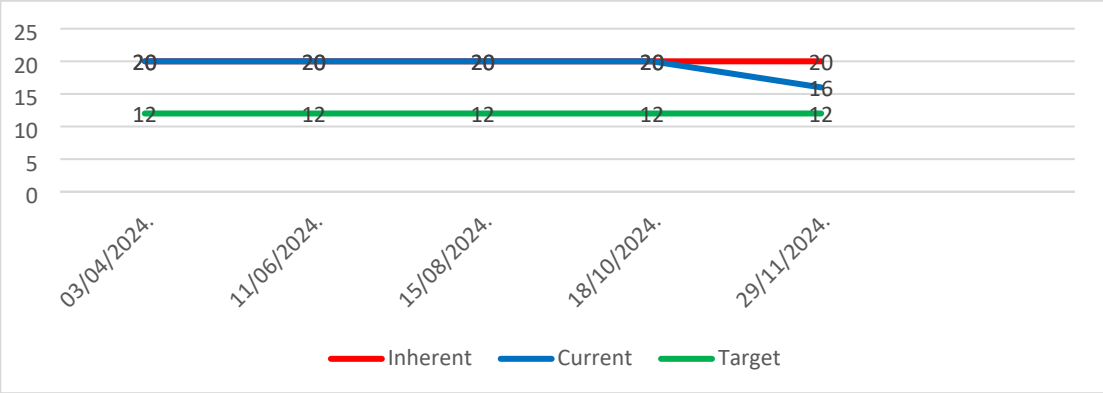
There is a risk that the Health Board does not plan adequately for outbreaks and incidents of communicable disease such as (but not solely) Measles, M.Pox, COVID-19, Pertussis etc.. This may be caused by the unpredictability of when the disease may first occur, the varierty of new and emerging threats, the variations in the nature of the required response to specific diseases, the availability and cost of associated resources (e.g. pharmaceutical products, workforce, estate, contact tracing, sampling, vaccination, communications), the scale of potential outbreaks, the difficulties in protecting specific vulnerable groups and members of staff in a timely way. This could lead to greater exposure of the public and staff members to communicable diseases causing an increase in cases, further transmission, interuption of health board services and in some cases death.

Mitigations/Controls in place	Additional Controls required
1. Health Protection Service established within BCUHB with a clear remit for enhancing the response to incidents and outbreaks in North Wales in accordance with the Communicable Disease Outbreak Control Plan for Wales. 2. Standard Operating Procedures relating to community sampling for specific diseases, including Measles, M pox, Avian Influenza, COVID-19 (although some remain to be developed) 3. Pathways established for response measures to specific diseases, for example, HNIG pathway and vaccination outbreak response for measles. 4. Health Protection Service responsible for the management of COVID-19 incidents in closed settings in North Wales 5. Strong links with Health Protection Partners including Public Health Wales and each of the 6 Local Authority Environmental Health teams. 6. Strong links with the Communicable Disease Surveillance Service to support the monitoring of trends in communicable diseases	a. No approved comprehensive procedure/plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB. (this point deleted as this is an aspect of a comprehensive outbreak plan)

7. Multi-agency simulation exercise undertaken in September 2023 in North Wales to test preparedness measures for specific outbreaks. 8. Access to and use of the national Case and Incident Management System: Tarian 9. Significant lessons identified from preparedness activities associated with national increase in Measles cases, leading to the development of tools, assets and pathways that could be adapted for use with other communicable diseases 10. IHC engagement with outbreak planning and preparedness activities highlighted in the IHC packs 24/25 11. Appointment of an EPRR Lead who is able to support with the development of an outbreak plan for the Health Board 12. Additional focus placed on staff (occupational health) vaccinations, with additional support provided for staff influenza and MMR uptake from the Health Protection Service 13. Strategic group established within the Health Board to lead on the development of plans and pathways for the management of suspected and confirmed cases of High Consequence Infectious Diseases (particular focus on Mpox Clade I). Preparedness activities to date include the testing of 'green routes' with the WAST Epi-Shuttle on each acute site, the preparation and testing of IPC guidance and sampling plans, confirmation of appropriate isolation areas on each acute site. and the initiation of preparedness activities within each IHC for the management of suspected and confirmed HCID cases. 14. National multi-agency simulation event to test local preparedness plans and processes for HCID Mpox Clade I – 'Fad Felen' 15. Contributions made to the development of national action cards for HCID cases. 16. NHS Executive audit of BCUHB HCID preparedness measures due early 2025.	

Actions	**Due Date**	**Progression Analysis**
Establish the link with EPRR lead to scope arrangements for a communicable disease outbreak management plan.	01/10/2024	Complete

Production of a draft outline of a communicable disease outbreak management plan	01/10/2024	Complete
To establish an operational group within BCUHB for the developing and shaping a communicable disease outbreak management plan (full list of members can be provided if required here) Action point is progressing – the operational group is currently engaged in activities to ensure preparedness measures are in place within the Health Board for identifying and managing suspected and confirmed cases of High Consequence Infectious Disease (HCID), notably Mpox Clade I. The group has representation from IHC's, Primary and Secondary care, Health Protection, EPRR, PHW, WAST, Health at Work and communications. The current need is to ensure that appropriate operational plans are in place to manage HCID cases.	01/03/2025	Progressing (revised date from 1 October 2024)
To prepare a draft copy of a communicable disease outbreak management plan An extension to the due date is anticipated as a result of current focus on HCID.	01/12/2024	Progressing
To run a simulation exercise across the Health Board to test the functionality and contents of the communicable disease outbreak management plan	01/02/2025	Progressing
Further revision of the plan following simulation exercises	14/02/2025	Progressing
Approval and agreement of the communicable disease outbreak management plan with an agreed schedule of simulation events.	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

There are a number of unpredictable situations that could arise and would have a potentially significant impact on the population.

CRR 24-19	**Risk Title:** Community Care Provision		**Date Opened:** 01/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**:	**Target Risk Date:** 31/03/2026

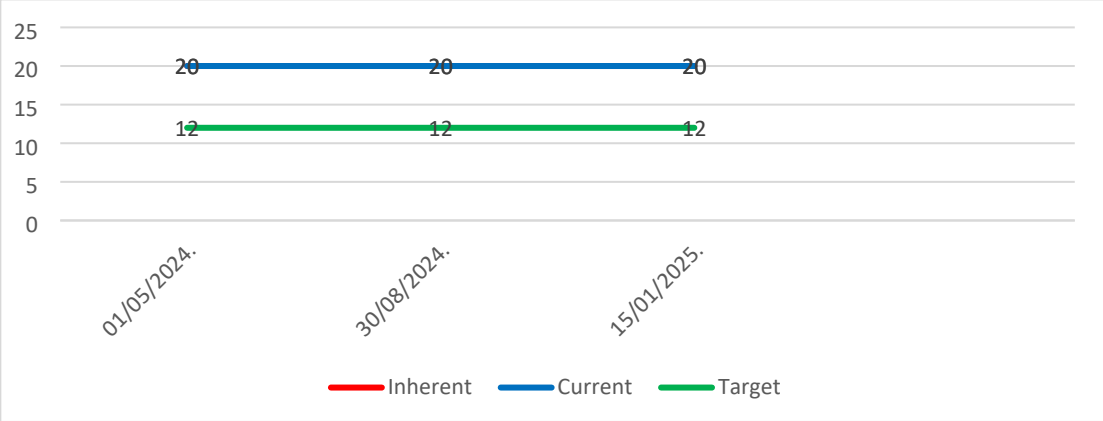
There is a risk that the Health Board may not be able to provide safe, effective and timely care to patients in the community, and the Health Board not fully meeting its obligation to commission and provide accessible and high-quality community care, D2RA, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient care in the community sector fragility, lack of available domiciliary care provision, delays of CHC assessments, staffing shortages and the fragility of care home sector
This may also be caused by a lack of investment in services and skill mix development, restrictions in IT systems and communication between different parts of the integrated team. This may lead to unnecessary admissions, delayed transfers of care, increased length of stay in hospital and poorer outcomes for patients, people not receiving end of life care in their place of choice.

Mitigations/Controls in place	Additional Controls required
1. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities 2. Primary Care Board has been established with the first meeting held May 2024, monthly meetings planned moving forwards. Community Care is reporting into the Primary Care Board around this risk. 3. Community Resources Team model bringing together agencies and professionals supporting locality populations. 4. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board. 5. Care home Quality Assurance Framework and tools in place 6. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur 7. Agreed joint escalation processes with Local Authorities for care homes of concern 8. Greater Health Board oversight of Community Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	a. Escalation and sustainability report requires commissioning to address risks associated with workforce and workload pressures allows for early identification and management. b. Programme management to be implemented to monitor and drive strategic priorities. c. Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group d. Strategy, focus and resources including staff, training and IT to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home. e. Additional Resourcing of CIVICA system (scheduling system for District Nurses), access to EMIS (GP Patient record system) community for teams. Connecting Care Implementation for community services

	f. Better arrangements for allocating available resources. g. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13 h. Improved joint planning with local Mental Health services i. Improved planning for access to diagnostics in the community setting j. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits k. Equity of resource to support community care and CHC transformation, innovation, management and governance. l. As part of the refresh of UEC structures work stream 4 focus's on Discharge m. Pathways of Care Regional Action Plan n. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again. o. Complete pre-placement agreements with all providers and implement strengthened contract monitoring

Actions	**Due Date**	**Progression Analysis**
Primary Care Board established	30/05/2024	Completed
Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans	31/03/2025	Progressing
Escalation process in place for community hospitals, community nursing and CHC	31/12/2024	Complete
Programme management to be implemented to monitor and drive strategic priorities.	31/10/2024	New action
Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group Get rid	31/10/2024	New action
Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits	31/03/2025	New action

Strategy and resources to be made available to support introduction of new roles, ways of working and models of service delivery.	31/03/2025	New action
Equity of resource to support community care and CHC transformation, innovation, management and governance.	31/03/2025	New action
Strategy, focus and resources to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home.	31/03/2026	New action
Joint commissioning plan with Local Authorities to increase domiciliary care capacity Following evaluation panels there is now a list of domiciliary care workers that are able to provide the more complex care. All will go on the new framework that is due to go live April 2025.	25/04/2025	Progressing
Review of community services model and development of business case to address gaps in capacity	31/03/2025	New action
Determine required level of Quality Assurance Framework increased frequency of visits, resource requirement and plans to implement. Final version of SOP for Clinical Quality Support Tools under the QAF is awaiting approval at the next Patient Safety Group on January 28th.	28/02/2025	Progressing



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

Rationale for Corporate Risk

The data on reduced care home placement, number of care homes in escalation due to quality concerns, significant numbers of patients delayed in hospital awaiting domiciliary care and reablement packages, and a current inability to meet Welsh Government unscheduled care targets - all of which indicate risk of harm due to insufficient safe provision in the community. –

Wider impacts resulting in the impacted access to and delivery of Community Care and CHC services is severely impacted and is affecting patient flow through secondary care, Primary care and Emergency/Urgent Service delivery, LA Care provision delivery and exacerbating patients' health conditions.

	Recognition of inherent score currently further controls needed. Lack of adequate investment and provision in domiciliary care.

CRR 24-20	**Risk Title:** Oncology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 19/12/2024	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 30/04/2025
There is a risk that patients may not experience a safe, effective and timely Oncology service provided by the Health Board. This may be caused by reduced substantive medical workforce, demands for oncological care, increasing numbers of NICE approved treatments for cancer, and patients remaining within the service due to developmed chronics condition. This could lead to poor patient outcomes, failure to meet Single Cancer Pathway target of 62 days and detrimental impact on the organisations reputation to the public, government and others.			

Mitigations/Controls in place	**Additional Controls required**
1. Medical locums in place to support gaps in substantive provision 2. Escalated requirement to support recruitment of medical oncology trainees within next 12 months 3. Supporting 2 NHS Locums to complete *Certificate of Eligibility of Specialist Registration* (CESR) and additional competencies to be eligible to become substantive in the future. 4. Development plan in place for 2 Senior Clinical Fellows with aim to train them to become substantive Consultants within 2-3 years. 5. Systemic anti-cancer treatment (SACT) Operational group established to improve processes and systems – collaboration with pharmacy. 6. Radiotherapy Oversight meeting established to monitor progress against plan and maintenance of target. 7. Developed extended non-medical nursing roles to support medical gaps including immunotherapy toxicity, cancer of unknown primary and metastatic breast and colorectal services. 8. Developed an extended non-medical radiotherapy role to support prostate cancer patients who require radiotherapy 9. Clinical Leads (Joint role) appointed.	a. Remaining substantive medical vacancies unfilled despite active recruitment – in line with national picture of vacancies and report by Royal College of Radiologists for Clinical Oncologists, medical locums use 34% - 50%. b. Lack of available high-quality data to provide robust capacity and demand modelling per tumour site, per clinical/medical oncologist c. Recurrent funding needs to be secured for 7 consultants and a number of temporary nursing and administrative roles (and other elements subject to RIGA) d. Inability to respond effectively to increasing demand for oncological treatments and new NICE-approved regimes e. Home care service is saturated meaning no further treatments can be transferred out of the day units to release capacity f. Lack of physical estate to expand services and/or recruit more staff. g. Outsourcing opportunities for the highest risk tumour sites, remains a gap, further exploration required. h. Gap and lack of clinical oncology trainees with multiple gaps limiting ability to ‘grow our own’. i. Collaboration with recruitment agencies to explore overseas consultant opportunities.

	j. There is an aim to implement nursing staff rotational opportunities to improve cover arrangements and skill mix but this is limited due to vacancies and amount of fixed term funded posts

Actions	Due Date	Progression Analysis
Continue to expand Systematic Anti-Cancer Therapy training with the oncology division and extend the operating hours of the day units, providing further capacity Opening hours until 6.30pm on all sites Mon – Fri. Unable to expand further without investment into additional nursing, medics and pharmacy.	Complete	Complete
Establish potential of a joint Consultant Oncologist role with Bangor University A Meeting was held, and the plan is for the university to provide 4 sessions to support a full-time position.	31/01/2025	Progressing
Progress plan to deliver more anti-cancer therapies from Ysbyty Gwynedd for residents living within the West of North Wales All treatments have been transferred, apart from those that can only be produced in the Centre area Pharmacy	30/08/2024	Complete
Complete Planning to repatriate the delivery of Stereotactic Ablative Radiotherapy into the Health Board A letter is being submitted to the JSCC requesting approval to proceed according to the established process commence as per process	30/04/2025	Progressing
Establish potential of undertaking shared recruitment with other cancer centres Discussions need to be initiated to address operational concerns, particularly the high risks associated with specific tumour sites	30/04/2025	Progressing
Work with informatics to support development of quality data Regular meetings are being held, and training plans are being developed to support correct use of the Welsh Patient Administration System. National queries have been raised regarding the duplication of work with SACT on Chemocare and WPAS, however, it is necessary to establish a secure link between the systems to improve quality and efficiency. Process mapping has been undertaken identifying areas to be resolved.	31/03/2025	Progressing
Escalated requirement to support recruitment of medical oncology trainees within next 12 months Funding has been provided following a discussion with ELT. Interviews are taking place 20/12/24 so this is completed	31/12/2024	Completed

To be completed following approval of escalation		Impact	Likelihood	Score
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15
	Target Risk Score	3	3	9

	Risk Appetite	Quality	15-19

Rationale for Corporate Risk

The combination of multiple factors, *including;*

- the inability to recruit substantially to Senior Medical posts,
- increasing reliability on availability of Locums
- large number of temporary staff, as a result of RIGA
  and increasing demand for oncological treatments, which has resulted in service gaps which have increased waiting times for patients to be seen and treated.

Delays to commencing treatment will result in significant patient harm and potentially premature death**.** NICE approved regimes indicate optimum time frames and that delay will decrease effectiveness of treatment. In general research has shown that every 4 week delay to commence (any cancer) treatment increases the likelihood of death by 10%. Escalation paper to Executive Lead and Chief Operating Officer indicated waiting times in east and centre were now 6 weeks (Dec 24)

11th October 2024 – Extreme risk within Gynae, Breast and Upper GI as a result of sickness and high use of Locums who can leave with one week's notice.

Waiting times to see a Consultant following referral range from 0 to 12 weeks depending on tumour site and clinical priority. The aim is to see patients within 2 weeks, so that treatment can commence quickly. This is not reported externally.

CRR 24-21	**Risk Title:** Ophthalmology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/25

There is a risk that patients may come to harm casued by the lack of a sustainable service model, unmanaged demands and the current capacity not being able to meet incoming demands. This could lead to, and result in, increased waiting lists and an increased risk of harm including irreversible sight loss, and litigattion due to prolonged wait times.

Mitigations/Controls in place	Additional Controls required
1. Train and Treat initiative in place to increase the number of procedures that can be done in a community/high street optometry setting. 2. Outsourcing solution for cataract procedures in place. 3. Development of High flow lists for cataracts in place.	a. Appoint Health Board clinical lead to secure professional oversight and leadership b. Development of a sustainable service model c. Ensure specialty demand, capacity and planning is delivered along with further mitigations to be developed to close any gaps in delivery. d. Release planned care funding to cover funding cut in RIGA2 process, this will enable significant positive mitigation for loss of high risk follow ups

Actions	Due Date	Progression Analysis
Convene a Health Board wide Ophthalmology summit to identify sub specialty leads to support service redesign, agree priorities and initiate work plan	28/02/2025	Progressing
To Appoint a Health Board Clinical Lead	30/06/2025	Progressing (revised date from 31/12/204)
Develop a work programme for service design and development (output of summit)	28/02/2025	Progressing
Resource activity as previously identified and reinstate eye care performance fund that has been reduced through RIGAII financial prioritisation	01/04/2025	Progressing

To be completed following approval of escalation		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20

Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Significant harm may occur including irreversible sight loss in high risk R1 & R2 patients (Glaucoma and Retinopathy). Large volume of patients on Patient Treatment List currently stands at 23,544 un-booked of which 963 are 2 years+

CRR 24-22	**Risk Title:** Orthodontics Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that patients under the Orthodontics Service may come to harm, this could be caused by the lack of consultant capacity to provide an effective and timely Orthodontics service care provided by the Health Board, backlog demand outweighs capacity available in both primary and secondary care, driving less favourable patient outcomes (psycho-social vulnerability amongst younger patient groups). Less conservative/preservative treatment options – meeting urgent need. Increased chance of requiring intervention general anaesthetics, intravenous antibiotics. This may lead to reputational damage and increased litigation.

Mitigations/Controls in place	Additional Controls required
1. Appropriate referrals pathway/ triage implementation (as per national pathway) 2. Dentist with Specialist Interest (DESI) and Tier 2 – wider, easily accessible pathways 3. PAN BCUHB approach dating patients according to length of wait into additional Waiting List Initiative (WLI) activity 4. Health prevention/promotion within primary care 5. Reviewing Academy Model to increase attractiveness of North Wales as a place to work to include upskilling/additional training for suitable Health Care Practitioners 6. Supporting hosting of undergrad training in North West Wales, online Continued Professional Development and microcredentials course for local people (including consideration for maternity leave, single parent etc.)	a. Continued shortfall of workforce across BCUHB needs recruitment strategy b. Continued conversations with external providers indicates limited outsourcing opportunity c. No restorative consultant service available d. No proactive comms to patients and stakeholders agreed e. Current service provision indicates ongoing service delivery shortfalls with recovery in excess of 5 years

Actions	Due Date	Progression Analysis
	31/07/2024	Complete

Agreement of BCUHB to advertise Consultant Orthodontists at top of scale following submission of SBAR in September 2023		
Successful appointment of 0.7 WTE Consultant Orthodontist	31/08/2024	Complete
Attempted but unsuccessful recruitment of Agency & NHS Locums Unable to complete	31/12/2025	Progressing
Review of workload of consultants across BCUHB to improve equity of access within BCUHB	28/02/2022	Complete
Temporary allocation of 2 additional sessions from Ysbyty Glan Clwyd to support patients in active treatment in Ysbyty Gwynedd up until Maternity commenced February 2024	28/02/2022	Complete
SBAR & options appraisal submitted for consideration of a primary/secondary care dental review in 2021, 2023, 2024	31/12/2024	Complete
Restorative Consultant re-advertisement	31/12/2025	Progressing
Submission of executive paper requestion stakeholder comms in relation to Orthodontic service provision in March 2024	31/03/2024	Complete
Orthodontic & Oral Surgery 'Getting it Right first time' (GIRFT) review	31/12/2024	Complete
National Benchmarking of service model and approach to service recovery for RTT stage 1 patients	31/12/2024	Complete
SBAR submission recommendation 2024: Continued procurement exercise to determine full treatment plan capacity with external providers-funding noted as available	31/12/2025	Progressing

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	2	4
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

	Waiting lists and waiting times have continued to grow with patients waiting in excess of 156 weeks for initial clinical assessment. Impact of vacant sessions across Health Board on capacity provision with limited opportunity to resolve the backlog position with a current BCUHB active workforce establishment at 2.2 WTE. Poor provision in some geographical areas. Lack of stability from Welsh Government around future Dental contracts. Patients awaiting treatment completion are dating back to referrals first received in 2017 highlighting significant delays in treatment pathways. Patients awaiting Patients referred for Max Fax treatment (waiting up to 156 weeks) are being returned to Orthodontics due to timescale lapsed since orthodontic referral. No current service provision for Restorative Dentistry for new or existing patients across BCUHB. Delays in Orthodontic provision impact surgical cleft optimisation delivered via Alder Hey Cleft outreach service. Clinical risk being held within the waiting lists. National shortage in Orthodontic consultants Infrastructure & estate restrictions on expanding Medical workforce. Current model of care is disjointed and lacking fluidity between primary & secondary care. Delay in sustainable service planning across BCUHB. Patients and parents reports the mental and physical challenges associated with unaddressed orthodontic issues as a result of delays into teenage years. Parents have reported orthodontic related bullying which has resulted in their child's withdrawal from education and social aspects of their childhood; also the inability to meet ministerial targets as required by Welsh Government.

CRR 24-23	**Risk Title:** Vascular Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that individuals may expeirence preventable harm and a poor experience whilst receiving care from the North Wales Vascular Service.This may be caused by current and projected future staffing challenges,a lack of capacity across the network a lack of clarity with regards secondary care and/ or end-to-end, vascular pathways. This could lead to increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, difficulties recruiting and retaining staff, staff health and well-being, reputational damange, increased costs, increased legal and financial claims.			

Mitigations/Controls in place	Additional Controls required
1. Management of bed base through assessment of clinical risk in place. 2. Optimising and streamlining management of inpatients and ensuring clear communication across site to ensure timely transfer and repatriation 3. Additional funding to support delivery of robust vascular services across hub and spoke sites, approved. This will allow capacity to be increased in key areas (i.e., Cardio Pulmonary Exercise Testing and Ward 3 staffing) and a number of agency/ locum appointments to be made permanent 4. Weekly case-note audits in place to monitor standards of record keeping, with results discussed at clinical governance meetings 5. Pathways are co-designed with an extensive group of delivery partners across the 3 sites 6. Local Vascular Delivery Groups in place for 2/3 IHCs (West and Central) in order to proactively identify performance concerns and manage risk 7. Development of Abdominal Aortic Aneurism (AAA) Quality Improvement programme. 8. Consultant vascular surgeon is picking up IR sessions	a. Development of Vascular Intranet pages to help share information, including clinical pathways, with staff, in a way that is simple and accessible b. Local vascular delivery groups to be operational across each IHC. c. Review of AAA surveillance protocol / pathway, to include management of persons turned down for AAA repair d. Implementation of deep-dive audit tool to enable quality audit of case notes e. Workforce and resource review to support development of Phase 2 Business Case f. Development of vascular workforce strategy aimed at improving recruitment. g. Improve the way that information relation to service quality via patient, carer and staff satisfaction and well-being questionnaires is used to inform continuous improvement h. Development of Quality dashboard, to support improved use of service and outcome data

9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need Interventional Radiology provision and/or can have an open Abdominal Aortic Aneurism (AAA)repair? 10. Enhanced clinical and programme governance to ensure learning from events and focus on quality	

Actions	Due Date	Progression Analysis
Finalise vascular intranet page as key place for network and wider Health Board staff to access the full range of information, policies, procedures and pathways relating the vascular network	31/03/2025	Progressing
Work with East IHC Medical Director to establish Local Vascular Delivery Group	31/03/2025	Progressing
Review AAA surveillance protocol / pathway to ensure timely monitoring of persons with an AAA not identified by Welsh Abdominal Aortic Aneurism screening programme.	31/03/2025	Progressing
Strengthen information, advice and support provided to people turned down for AAA repair, and ensure 'register' of persons turn down is maintained	30/05/2025	Progressing
Implement quarterly quality audit tool to enable network to proactively identified areas for improvement	31/03/2025	Progressing
Work with key delivery partners to develop a (Phase 2) vascular and diabetic foot business case	31/03/2026	Progressing
Develop and implement vascular training and workforce strategy to improve recruitment and retention across the network	31/03/2026	Progressing
Revised patient, carer and staff satisfaction and well-being questionnaires to be regularly disseminated, and findings analysed in order to inform continuous improvement	Ongoing	Progressing
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	Ongoing	Progressing

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Demand for vascular care in North Wales is increasing, however, recruitment to vascular services is not increasing as at the same rate. Whilst this is a UK-wide issue, the history of vascular services in North Wales, makes recruitment and retention across the network a particular concern. Whilst the network has been successful in embedding a wide-ranging improvement programme, the impact of this unstable workforce risks undermining the quality and safety of care provided, both now, and in the future. Work ongoing to develop a workforce framework for the service to allow monitoring.

CRR 24-24	**Risk Title:** Renal Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that individuals may expereince preventable harm, and have a poor experience whilst waiting for dialysis. This may be caused by extended waiting times for vascular access procedures, a lack of capacity, inequity in resource allocation across the Health Board. This could lead to, increased hospital admissions, longer hospital stays, increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, reputational damange, increased costs, legal costs and financial claims.			

Mitigations/Controls in place	Additional Controls required
1. Close regular scrutiny of waiting lists at a vascular and renal network level. 2. Informal management of waiting lists on a networked basis to support prioritisation of cases, where possible 3. Additional capacity provided by Locum Consultant.	a. Formal agreement to the establishment of a single Pan-BCU list, rather than 3 separate Integrated Health Community (IHC) Clinic and Theatre lists. b. Additional capacity to support reduction of current wating list in the East, to a more manageable position. c. Recruitment to 2x vacant Consultant posts d. Re-allocation of resources across the Network, to enable equitable access to interventions locally.

Actions	Due Date	Progression Analysis
Submit Waiting List Initiative request to facilitate additional theatre lists, in order to reduce current backlog 2 requests submitted, one declined due to lack of Theatre staff availability, and awaiting confirmation on 2nd request	28/02/2025	Progressing (revised date from 30/12/2024
Undertake Workforce review across entire Service to ensure equity across the Region	30/05/2025	Progressing (revised date from 30/12/2024
Review Theatre provision, particularly in relation to overrunning lists, which result in Renal access patients being cancelled	30/05/2025	Progressing (revised date

Theatre utilisation group, first meeting 19/02/2025, has been established and will lead on this work.			from 30/12/2024

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

There is currently a significant backlog of people waiting for Vascular Access Clinics and Theatre Appointments in the East IHC. This situation has arisen for a variety of reasons, but principally, because:

a. Higher **demand** in the East due to its larger population size, together with the fact that it has the largest dialysis unit.
b. An inequity in **capacity** across the three IHCs to support renal access – the East having the fewest number of clinics sessions and theatre lists.

Reducing the current backlog and waiting list is critical to preventing further in-line sepsis. A peer review of Renal Vascular Access (2022) concluded that whilst BCU outcomes from renal vascular procedures were excellent, further work was required in order to:

- Ensure a dedicate group of Vascular Surgeons to complete renal access procedures – with flexibility to move across sites
- Dedicated Clinics for Renal VANS alongside surgeons (on each site)
- Dedicated Theatre lists on each site – reflecting the demand of each site's renal population

Whilst these recommendations have been implemented in Central and West IHCs, it has not been possible to secure such provision in the East.

	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 010/7/2025
There is a risk that patients for the Dermatology and Plastic Surgery Services will come to harm, this may be caused by lack of a sustainable service model, unmanaged demand and current capacity not able to meet incoming demand, this may lead to increasing waiting list increasing risk of harm caused by length of wait.			

Mitigations/Controls in place	Additional Controls required
1. Prioritisation of urgent suspected cancer to mitigate clinical risk 2. Provision of Waiting List Initiative activity to provide short term additionality 3. Development of insourced arrangements to provide interim additional capacity for a 12-18 month period 4. Appointment of clinical leads to support service redesign 5. Introduction of Teledermoscopy with a commensurate increase in treatment capacity (minor operating procedures)	a. Appoint a specialty managerial lead to take forward service redesign. b. Approve and implement increased treatment capacity.

Actions	Due Date	Progression Analysis
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales	Ongoing	Progressing
Dermatology – Fund requisite MoPS Minor Operating Procedure capacity to support expansion of Teledermoscopy	01/07/2025	Progressing
Dermatology - Establish the viability of an expanded GP with Special Interest Model for referrals to Secondary Care	30/06/2025	Progressing
Plastic Surgery - Agree and Sign updated SLA between Partner Organisations	30/04/2025	Progressing
Plastic Surgery - Implement additional dressings clinic to address current variation across North Wales	01/07/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15

	Target Risk Score	3	3	9
	Risk Appetite			
	Rationale for Corporate Risk			
	Significant volumes of patients remain in the list (currently 13,212 unbooked), within these there will be undiagnosed cancers and the obvious risk follows regarding delayed diagnosis and treatment.			

	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 31/12/2025
There is a risk of increased avoidable harm caused by unsustainable service configuration for Urology in North Wales This could be caused by the inability to recruit to consultant posts driven by unattractive on call rota and lack of recognised best practice equipment (robotic assisted surgery), the lack of specialist knowledge for cancer pathways, issues with access to estates and a lack of clinical leadership. This may lead to the inability of the Health Board to deliver timely and appropriate care to the population of North Wales. As detailed in the RCS and GIRFT reviews, there is a need to develop a provision within a network model to ensure that the service achieves the recommendations from external reviews and complies with national/professional guidance. If the actions within the Urology Improvement Plan are not achieved, the ability to mitage the known risks will not be possible, which will have an adverse impact on patients access to the service in North Wales, as well as the reputuation of the Health Board.			

Mitigations/Controls in place	Additional Controls required
1. High use of locum provision 2. Outsource of service, case by case, whilst commissioning discussions take place. 3. Anuual commissioning of service in place 4. Commission of Robotic Assisted Surgery prostates to UCL 5. Office of the Medical Director currently supporting with Clinical Lead input 6. Monthly meeting with Welsh Government and NHSE to provide assurance and update on the risks currently identified and actions within the Improvement Group.	a. Agree mitigation to move to 2 site model if staff becomes unsafe at 1 site. b. Review purchase of an appropriate Robotic Assisted Surgery platform for prostatectomies c. Clinical facilities and equipment investment identified in the Urology Improvement Plan under the Planned care theme not yet in place

Actions	Due Date	Progression Analysis
Scoping, development and implementation of a revised network model of care for on call.	01/04/2025	Progressing
Review current outsource provision and align Multi-Disciplinary Team meeting for in-reach support in specialist discussion and decision. Review current outsourced/commissioned agreements to provide care closer to home and review opportunities to repatriate cancer procedures at BCU. New arrangements being onboarded with Arrowe Park	01/12/2024	Complete

Cancer services with support from the OMD to advertise for a Urology Cancer lead.	01/11/2025	Progressing
Agreement to fund the MyMR PSA tracking license internally through the Planned Care funds for 24/25 whilst Digital, Data a Technology colleagues look at the integration with AB colleagues and supplier.	01/04/2025	Progressing

To be completed following escalation approval

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	3	6
Risk Appetite			

Rationale for Corporate Risk

Urology service is one of the areas of Clinical Concern and has been subject to an invited review by The Royal college of Surgeons. The identified risk for the services are:

- Increased financial expenditure due to locum provision on the on call rota
- Fragile Out Of Hours on-call rota across BCU
- Delay in patient care with an inability to meet targets for cancer diagnosis and treatment.
- Failure to deliver care closer to home.
- Difficulty in recruiting to provide a sustainable cancer service

Appendix 3 – Risk Governance Arrangements Maturity Report – February 2025.

1. Risk Management Report

The purpose of this report is to present the governance arrangements of the Divisions/Directorates/IHCs in relation to effective risk management, in line with the Risk Framework and Risk Management Procedures. Quarterly audits are conducted to assess each Division/Directorate/IHC, providing recommendations to the responsible Director and assurance to the Head of Risk Management. This report highlights items for assurance or escalation, focusing on the completeness and accuracy of risk registers, timeliness of risk reviews and updates, governance and oversight of risk management, and compliance with risk management training.

Within the audit the team review: Completeness and accuracy of the risk register, Timeliness of risk reviews and updates, Governance and oversight of Risk Management; Risk Management training compliance.

This report provides an in-depth analysis of current risk management practices, progress, and key performance indicators (KPIs) as monitored through our Risk Framework and Risk Management Procedures. The report details the latest high risks reported for the last month.

2. Governance Risk Register Report

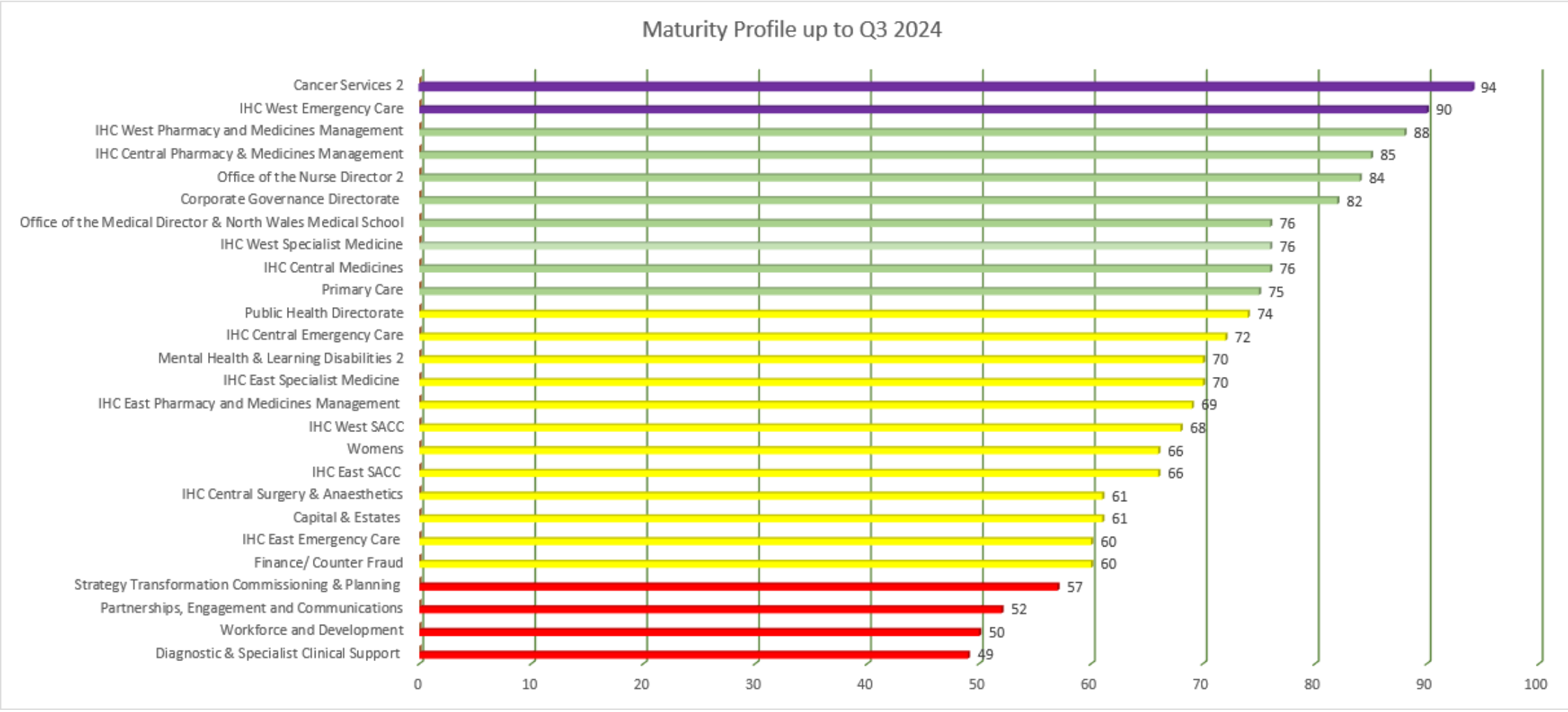
2.4 Quarter 3 2024

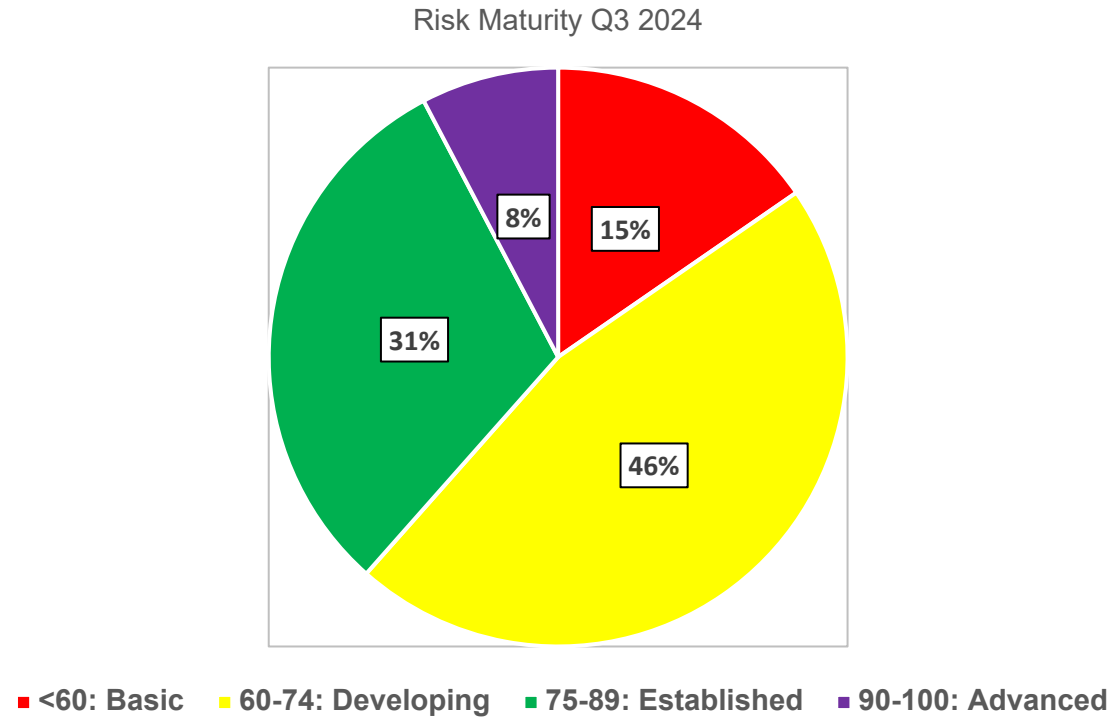
24 out of the 27 Directorates and Divisions have been audited in Q3, 5 audits have been completed at the end of Quarter 3 2024 (including one re-audit - OND). Of these 5, 1 scored as ‘Established’, with 4 ‘Developing’. The goal for all divisions is to progress towards the ‘Established’ level.

Work will be ongoing from the Corporate Risk Team to provide support, training and encourage improvement of those that fall below Established.

The detail in the graphs below provides an overview, of how the different workstreams are progressing, in terms of their risk maturity.

- ⇑ ***Advanced (Risk Maturity 90-100)***
- ⇑ ***Established (Risk Maturity 75-89)***
- ⇑ ***Developing (Risk Maturity 60-74)***
- ⇑ ***Basic (Risk Maturity <60)***





2.2 December Risk Audits

The following Divisions/Directorates/IHCs were audited during December 2024 and presented at February 2025 Risk Scrutiny Group:

- IHC East – Emergency Care 60
- IHC East – Medicine 70
- IHC East – Pharmacy 69
- IHC East – Surgery & Anaesthetics 66
- Office of the Nurse Director 84

Overall Risk Management Rating (out of 100 points)
90-100: Advanced
75-89: Established
60-74: Developing
<60: Basic

3. Key Highlights November Audits

3.1 Directorate Risk Maturity Levels

IHC East – Emergency Care (60 points – Developing):

The Team continue to develop their risk management arrangements, with regards to the quality of risk descriptors reflecting this effort and the overall audit score of 60 provides a solid foundation for progressing to the next level of maturity, with some minor housekeeping adjustments needed in the Datix system and a few easily addressable points to improve the score going forwards.

While the action plans are generally of a good standard, they would benefit from clearer articulation of SMART objectives in the description sections along with ongoing review updates of the target and reviews.

Improvements Needed: Action plans require a "housekeeping" review, as some risk actions were missing detailed information relating to SMART criteria

IHC East - Medicine (70 points – Developing):

The General Medicine Team has demonstrated clear engagement with risk management processes, ensuring that risks are regularly reviewed and aligned with target dates.

Strengths: The Team maintains an active and well-defined risk register, with risks appropriately assigned to their respective tiers.

Improvements Needed: Housekeeping is needed, particularly in updating the "action progression" field and ensuring all action plans are SMART.

IHC East - Pharmacy (69 points – Developing):

The risk entries and updates are completed to a good standard, reflecting a strong understanding of the risks involved. The Risk Lead demonstrates a high level of expertise in risk management and has an excellent working relationship with the Regional Risk Manager.

Strengths: Regular monthly catch-up meetings have now been established, ensuring consistent communication.

Improvements Needed: The risk descriptions should be articulated more clearly using the risk, cause, and effect format

IHC East – Surgery & Anaesthetics (66 points – Developing):

SACC have maintained clear engagement with the Corporate Risk Management Team, ensuring timely updates of risks to ensure that they align with the corporate and local standards and procedures.

Improvements Needed: Some general housekeeping of the risk descriptors does need to be undertaken along with population of all mandatory fields.

Office of the Nurse Director (84 points– Established):

This was the second audit of the Office of the Nurse Director (original audit carried out in August 2024 scoring 88 - Established). The results show consistency with the first audit in most areas as well as progress against the agreed action plan. Risks are being completed correctly with all mandatory fields filled, descriptions following the health board's formatting and focussed on risks rather than issues.

Strengths: Overall, there have been some incremental improvements to the management of risks, a training review, and clarity around risk leads, but this has been offset by overall fewer action plans in date, resulting in an overall reduction in risk governance maturity rating.

4. Themes in Recommendations

Key themes across divisions for Quarter 3 included the need for:

Action Plans: To ensure risks are mitigated effectively, all directorates must review and develop action plans that are specific, measurable, achievable, realistic, and time-bound. Specific Action Plan training is being offered by the Risk team and targeting all the relevant risk leads, with good engagement from Directorates and compliance is being monitored.

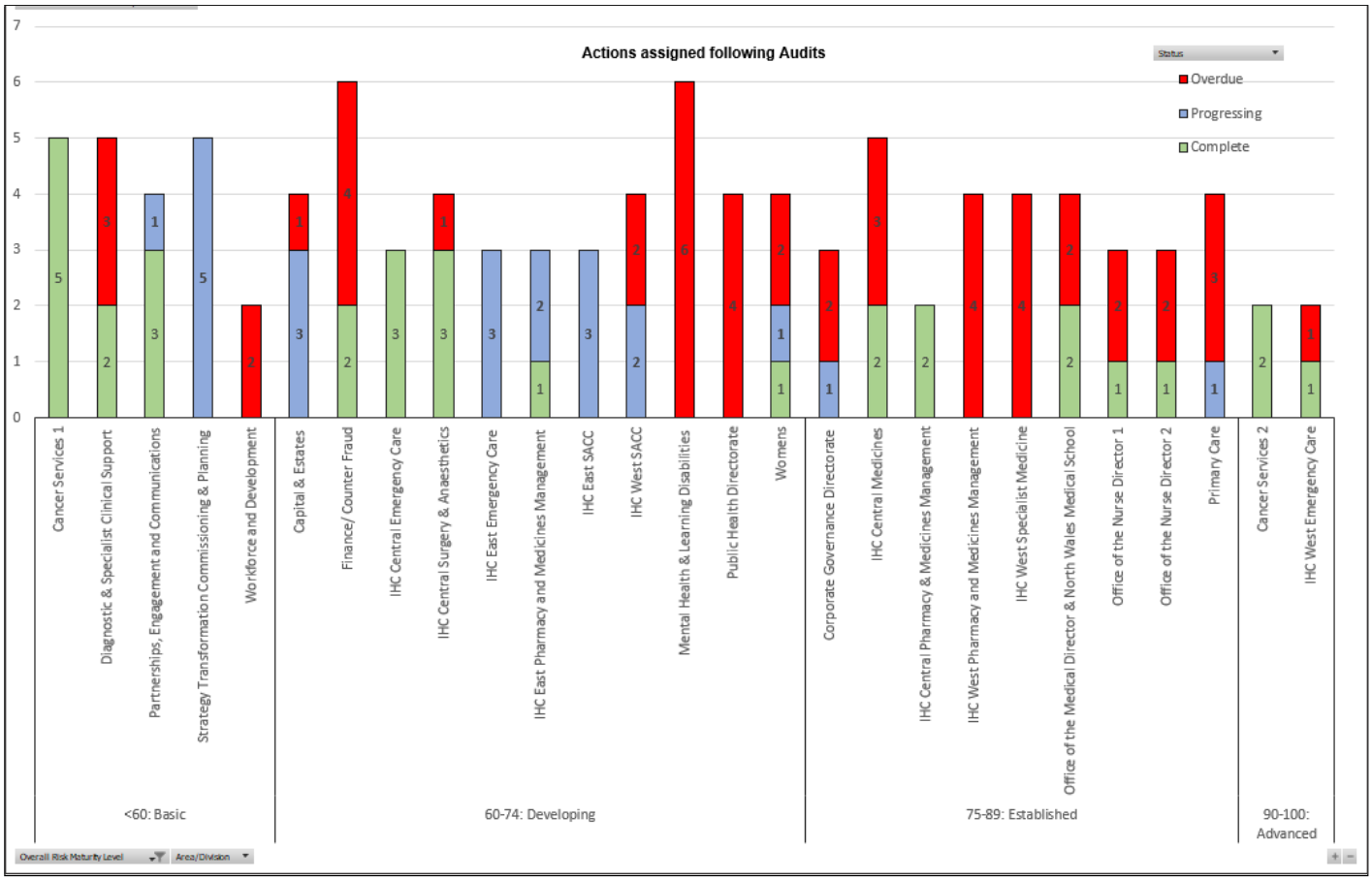
Training and Support: Many divisions noted gaps in risk management training, highlighting the need for targeted Level 2 training across departments. The Risk team are supporting key leads being added to face to face/virtual training.

5. Actions arising from all the Audits

The graph below provides a full breakdown of ***actions*** that have been assigned to each workstream following each Audit, and how they are performing in relation to actions status (Dates are set by the directorate/division).

Complete 34%, Progressing 20% and Overdue 45%

There is a clear need for continued focus on closing overdue actions and driving further maturity across all directorates/divisions and to be realistic with the time it takes to complete actions. Efforts are actively underway to embed improved practice, with a focus on closing and completing outstanding actions. This ongoing work is essential to ensure continued progress in improving risk maturity.



6. Risk Register Summary

Table 1 below stratifies the risks recorded within the HB:

Table 1: Summary of Risk Assessment Scores

Risk Analysis	Number of Risks			
	Nov 24	Dec 24	Jan 25	Feb 25
Corporate Risks	**18**	**19**	**19**	**24**
Corporate Risks Reductions in Scores	CRR24-18 Outbreaks 20 to 16	None	None	None
High Risk (>= appetite): Risk Score of 20-25 (Red)	26 (no risks scored at 25)	⬆40 (no risks scored at 25)	32 (no risks scored at 25)	⬆34 (1 risk scored at 25)
High Risk (< appetite): Risk Score of 15-19 (Red)	99 ⬆	98 ⟺	140 ⬆	⬇108
Moderate Risk: Risk Score 9-14 (Amber)	299 ⟺	308 ⟺	324	313⟺
Tier 3 Risk: Risk Score of 1-8 (Yellow)	153 ⟺	148 ⟺	152	148⟺
Total	**595** ⟺	⬇ **584**	**608**	**627**⬆

Closed	**35**	**22**	**11** ⬇	**26** ⬆
Individual Actions Closed on Live Risks		**13**	**2** ⬇	**7**

*'Closure rates' and 'total rates' are relatively stable from an annual position in line with previous report to the Risk Scrutiny Group.

Table 2: Titles of Risks Reported Last Month

ID	Title		Opened	Risk level (current)	Area/Secondary/Corporate	Linked CRR
5468	Blood Sciences 24/7 service delivery – building safety risk	This is due to the presence of RAAC in the roof above the Biochemistry automation lab and the link corridor to Specimen reception, Blood transfusion and Haematology.	13/01/2025	25	Pathology	CRR24-06

Risk escalated to Executive Team by the service and to Executive Director of Finance for further mitigations and actions put in place.

7. Key Performance Indicators (KPIs)

Significant decrease in Overdue Risks. Support for service leads, monitoring and engagement by the Corporate Risk Team.

Table 3: Key Performance Indicators (KPIs) as monitored through our Risk Framework and Risk Management Procedures.

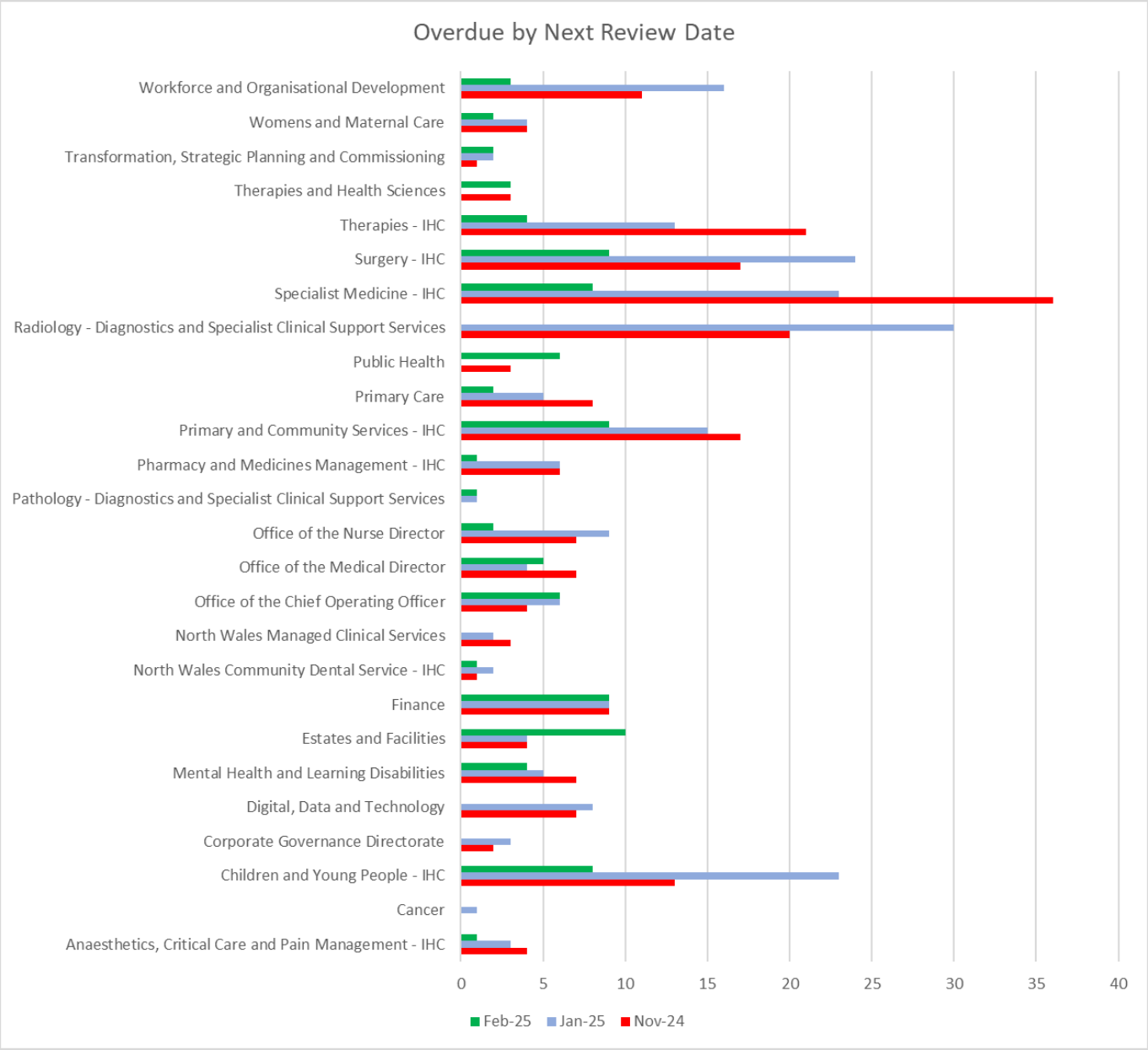
	Baseline June 2024	Nov 24	Dec 24	Jan 25	Feb 25
Overdue Risks	53% overdue risks, accounting for 319 risks.	19%, with only 116 risks overdue.	37% with 218 risks overdue. ⬆	37% 230 risks overdue.	16% 105 risks overdue
Quality Assurance (QA) Rate	40%	95%	97%	96%	95%
Individual Actions Overdue	Data not available	6% of individual actions are overdue.	⟷ 7%	8% ⟷	23% ⬆ 494 out of 2126 individual actions
Risks with No Action Plans	33% of risks had no action plans.	4%	⟷ 8%	8%	5% ⬇

Risks Beyond Target Date for Score reduction:	32% (193 risks) beyond target date.	11% (66 risks).	15% (89 risks)	18% (110) ⬆	4% (27) ⬇

8. Overdue by Next Review Date

This graph presents data on various areas and divisions, highlighting the number of overdue risks by review dates across time periods from November 2024 to February 2025. The Corporate Risk Management Team has been proactive in collaborating with Risk Leads across BCUHB, diligently following up and providing support to ensure updates to these risks. Their efforts have culminated in improved outcomes for February. With only 4 directorates with 10> overdue risks.

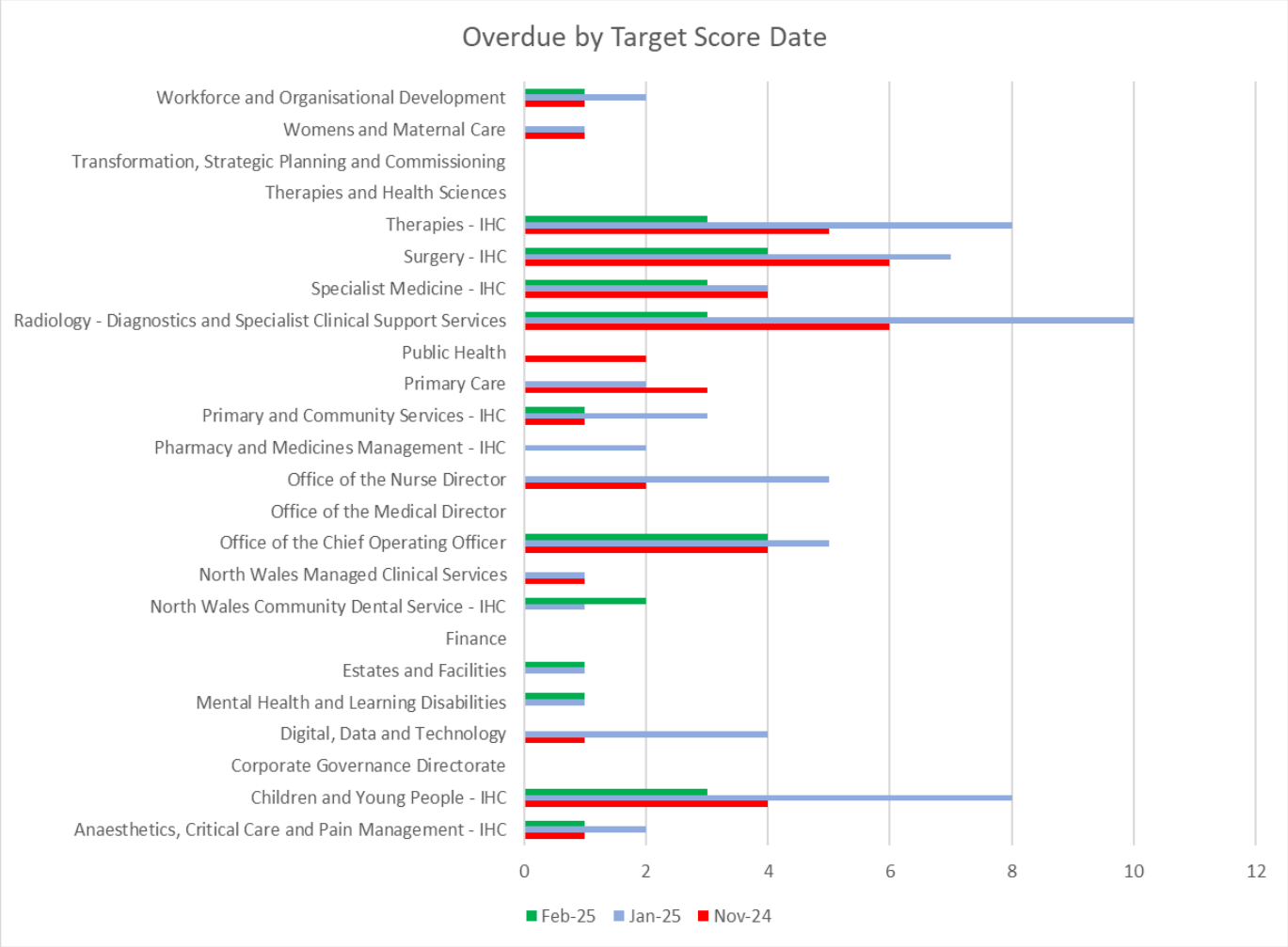
Area/Secondary/Corporate	Central	East	Pan BCU	West	Total
⊞	3	1	6	10	20
⊞ Children and Young People - IHC	9	1	2	3	15
⊞ Specialist Medicine - IHC	5	3	1	6	15
⊞ Primary and Community Services - IHC	1	1	4	6	12
⊞ Therapies - IHC	6	1	1	4	12



9. Overdue by Target Score Date

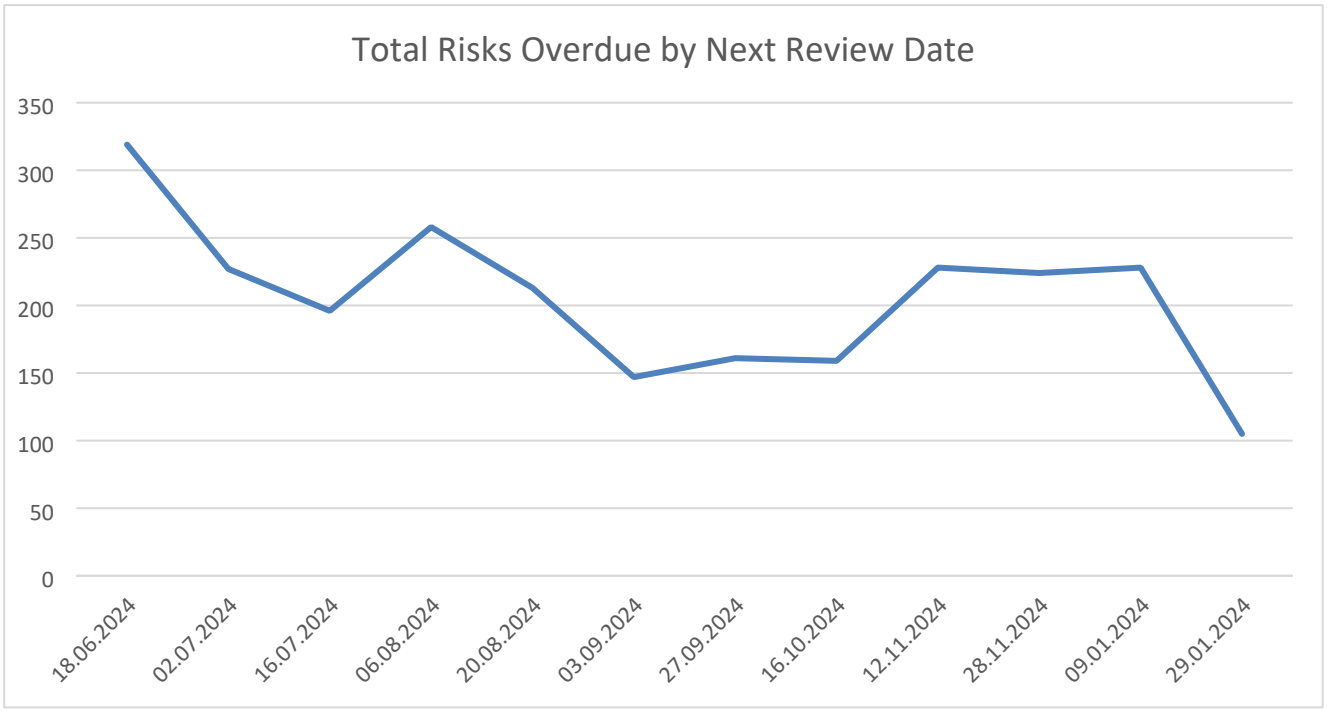
The graph presents data on various areas and divisions, highlighting the number of overdue risks by target score dates across time periods from November 2024 to February 2025. Notably, the Corporate Risk Management Team has been proactive in collaborating with Risk Leads across BCUHB, diligently following up and providing support to ensure updates to these risks. Directorates which have been consistently low in managing overdue were:

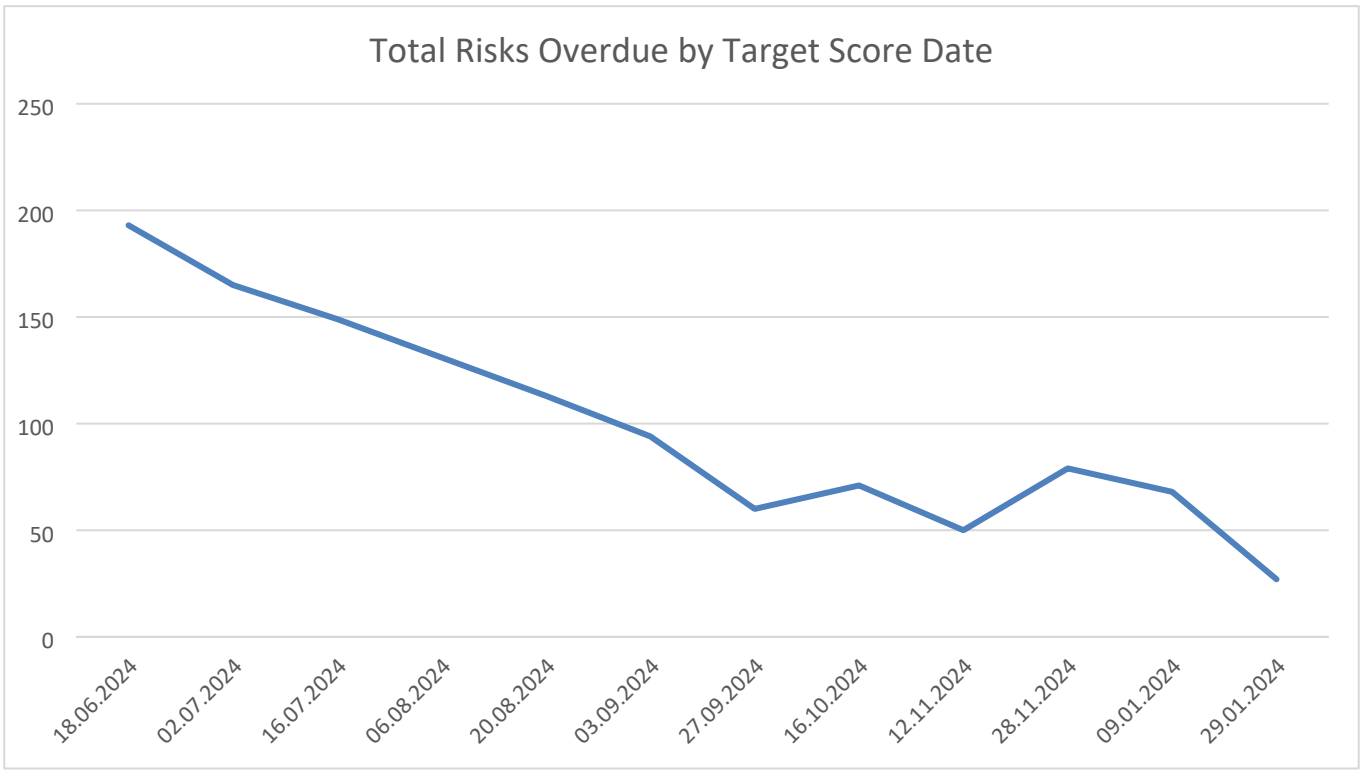
- Office of the Medical Director
- Finance
- Corporate Governance Directorate



10. Overall risk numbers overdue

This graph illustrates data from various areas and divisions, showcasing the number of overdue risks by target date for reducing the score.


Total Risks Overdue by Next Review Date
350
300
250
200
150
100
50
0
18.06.2024
02.07.2024
16.07.2024
06.08.2024
20.08.2024
03.09.2024
27.09.2024
16.10.2024
12.11.2024
28.11.2024
09.01.2024
29.01.2024


Total Risks Overdue by Target Score Date
250
200
150
100
50
0
18.06.2024
02.07.2024
16.07.2024
06.08.2024
20.08.2024
03.09.2024
27.09.2024
16.10.2024
12.11.2024
28.11.2024
09.01.2024
29.01.2024

7. Next Steps

- Share feedback and specific recommendations with each Directorate for action.
- Conduct follow-up audits to assess progress in March 2025 for all Q3 ‘Developing’ audits escalating and concerns to the Group.
- Monitor and provide support for overdue actions in relation to risk audits

Appendix 4 - 'Emergency Preparedness Review of Risks' submitted to Risk Scrutiny Group and PPHP for Assurance

A paper was brough to PPHP on 22 October 2024 which outlined immediate steps being taken to support Civil Contingencies preparedness following the commencement in post of the EPRR Lead in July 2024. An action from PPHP at that time was for the EPRR Lead and Head of Risk Management to review the Corporate Risk Register.

That review has now been undertaken which demonstrated that there is a lack of detailed Civil Contingencies risks on the Corporate Risk Register. To rectify this, following the commencement of additional resource into the EPRR team in February 2025, an urgent Risk Assessment work programme has been agreed. Escalation of any high scoring risks will be put forward to the Risk Committee for consideration of inclusion in the BCUHB Corporate Risk Register.

By way of context, the Health Board is a Category 1 responder as defined within the Civil Contingencies Act 2004. From natural hazards and public health emergencies to accidents and malicious threats including those from cyber-attacks, terrorism and state sponsored activity there is a statutory requirement on the Health Board to assess risk that could lead to an emergency and achieve an appropriate level of preparedness to respond to the consequence of those risks across North Wales.

The UK Government has produced a number of documents to assist in Civil Contingencies risk management and assessment (National Resilience Planning Assumptions, Local Risk Management Guidance, UK National Security Risk Assessment (NSRA – the NRSA identifies and assesses the most serious risks facing the UK, whilst not every risk is captured it aims to identify a range of impacts representative of the UK risk landscape. It supports risk management, planning and response and is a fundamental basis for EPRR strategic risk management). These UK risk documents are protectively marked "official sensitive" and not in the general public domain."

From the NSRA, Welsh Government have produced the Wales Risk Register that reflects the circumstances and characteristics particular to Wales these risks include:

- Terrorism
- Cyber
- State Treats – Geopolitical and Diplomatic
- Accidents and system failures
- Natural and environmental hazards
- Human, animal and plant disease
- Societal, conflict and instability

The North Wales Local Resilience Forum (LRF) use the Wales Risk Register to identify risks that are relevant within the North Wales region and will identify additional regional risks relevant to the specific environment and infrastructure (for example simultaneous closure of Britannia and Menai Bridge). Utilizing the identified risks on the North Wales Risk Register as the reasonable worst-case scenario the BCUHB EPRR service will

develop a BCUHB EPRR risk register. Risks scores will be considered and reviewed against the BCUHB Risk Management framework /procedures and will be presented back to the committee for assurance, identifying any gaps in controls, mitigation and actions. Escalation of any high scoring risks will be put forward to the Risk Committee for potential inclusion in the BCUHB Corporate Risk Register.

Using the EPRR risk register the Civil Contingencies Assurance Group (CCAG) chaired by the Executive Director of Public Health and SRO for EPRR, will receive a headline planning report which will:

- Set the benchmark against which preparedness can be assessed
- Articulate the requirements and set clear expectations
- Identify areas where controls are required to enhance resilience

The headline planning report will consider:

1) Status of any plan(s) ie No plan / Draft Plan in Development / Plan in place
2) When the plan was last reviewed ie <1year, 1-3 year, >3 year
3) What training event(s) have addressed this planning assumption / risk in the past 3 years
4) What exercise event(s) have addressed this planning assumption / risk in the past 3 years

Teitl adroddiad: ***Report title:***	Standing Orders Reservation and Delegation of Powers
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 04 March 2025
Crynodeb Gweithredol: ***Executive Summary:***	Since the Audit Committee in November, a review of the Standing Orders has been taking place. Changes are highlighted in red in the attached Appendix 1. The changes to the Standing Orders are minor amendments to job titles and directed amendments from NHS Wales. The Reservation of Delegation has been simplified and is agreed amendments approved at the Board meeting, as part of the CEO Report, in January 2025 have been included.
Argymhellion: ***Recommendations:***	• **APPROVE** the changes to the Standing Orders and • **NOTE** that the Reservation and Delegation of Powers are being re-drafted to make them clearer.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1 Building and Effective Organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The changes as highlighted in this paper are within the legal framework.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not required for this change.

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	
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?***	None identified
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	None identified. There are risks should the Health Board not make the appropriate changes to the Standing Orders, this paper however, ensure that the appropriate changes are made in accordance with good governance practice and within the legal framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None identified.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None identified for this report.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The proposed changes to the Scheme of Delegation have been shared with the Executive Director of Finance and Director of Corporate Governance who agreed that the direction of travel is the correct one but further work and consultation is required.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None identified
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	This paper will be available in public.
Next Steps: ***Implementation of recommendations***	
List of Appendices: Appendix 1 – Standing Orders	

1. SITUATION

The purpose of this report is to seek the support of the Audit Committee to propose changes to the Standing Orders Reservation.

2. BACKGROUND

The Board has approved Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved for the Board, a detailed scheme of delegation to officers and Standing Financial conduct of the Health Board and define "its ways of working".

Director of Finance and the Director of Corporate Governance have now undertaken the annual review of the Standing Orders Reservation and Delegation of Powers, in conclusion the Scheme of Reservation and Delegation of Powers was overly complex and confusing.

The review is being undertaken in the context of Foundations for the Future and whilst the review is pretty straightforward feedback from the workshops in relation to Foundation for the Future Programme has provided invaluable insights into the decision making and delegations for the Health Board which is consistent with the views of the Director of Corporate Governance and Executive Director of Finance. Therefore, more time is required to simplify the presentation of these and ensure a communication plan is in place, therefore the review will be considered at the Audit Committee in May 2025.

NHS Wales has written with amendments to the Model Standing Orders, advising of a number of amendments. The purpose of these amendments are to ensure consistency relating to:

(i) The eligibility requirements for the chair, vice-chair and non-officer members/non-executive directors of the Board.
(ii) The provisions relating to the appointment of officer members to boards of Local Health Boards.
(iii) The arrangements for appointing the Trade Union Member to a board of Local Health Boards.
(iv) The timescales for the publication of board and committee agendas and papers.

Clarity has been sought about the new publication timeframe for papers, specifically what '5 clear days' would look like in practice and the following guidance has been issued,

"5 clear days are calendar days (not working days) and they do not include the date the papers were sent or the date of the meeting. For example, if a meeting was due to take place on Wednesday the 29th of January, the papers should be sent on Thursday the 23rd of January – leaving 5 clear days between the date the papers were sent and the date the meeting took place – despite there being a weekend between"

3. GOVERNANCE AND RISK

The Audit Committee has responsibility on behalf of the Board to review and consider the Governance Framework for the Health Board.

4. CONCLUSION

This report has outlined the proposed changes to the Standing Orders and Reservation and notes that the Delegation of Powers are being reviewed.

5. RECOMMENDATIONS

The Audit Committee are asked to:

- **APPROVE** the changes to the Standing Orders and
- **NOTE** that the Reservation and Delegation of Powers are being re-drafted to make them clearer.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Standing Orders

Reservation and Delegation of Powers

Betsi Cadwaladr University Health Board

Foreword

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

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

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

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

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

Contents –

Section A – Introduction

Statutory Framework

i) The Betsi Cadwaladr University Health Board (the Local Health Board - LHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, "the Establishment Order".

ii) The principal place of business of the LHB is – Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

iii) All business shall be conducted in the name of Betsi Cadwaladr University Health Board, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

ix) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

v) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven LHBs in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) Specialised services for –
   (i) Cancer and blood disorders,
   (ii) Cardiac conditions,

(iii) Mental health and vulnerable groups,
(iv) Neurosciences, and
(v) Women and children,

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

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

vi) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

vii) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

viii) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014).**

ix) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

x) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

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

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

xii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

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

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

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

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

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

xiii) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in

the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xiv) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xv) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS Framework

xvi) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xvii) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xviii) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

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

xix) The Welsh Ministers, reflecting their constitutional obligations and legal

duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xx) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxi) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxii) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Betsi Cadwaladr University Health Board and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxiii) LHBs shall ensure that an official is designated to undertake the role of the Director of Corporate Governance/Board Secretary (the role of which is set out in paragraph xxxiii below).

xxiv) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxv) The SOs of the LHB (together with SFIs and the Standards of Business Conduct Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule* 4.

xxvi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance/Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Corporate Governance/Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

xxvii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxviii) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance/Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

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

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

The role of the Director of Corporate Governance/Board Secretary

xxxi) The role of the Director of Corporate Governance/Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and

support to the LHB Chair and other Board members. Independent of the Board, the Director of Corporate Governance/Board Secretary acts as the guardian of good governance within the LHB. The Director of Corporate Governance/Board Secretary is responsible for:

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

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

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

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members ~~(appointed by the Board)~~ (appointed by Non-Executive Members of the Board and the Chief Executive).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Executive Director of Finance. Officer and non-officer members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

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

officers.

Non Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a nominated current member or employee of a Third Sector organisation within the LHB area; a nominated trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

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

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i) Either or both persons may attend and take part in Board meetings;
ii) If both are present at a meeting, they shall cast one vote if they agree;
iii) In the case of disagreement, no vote shall be cast; and
iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

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

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction

- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i) Schedule of matters reserved to the Board;
ii) Scheme of delegation to committees and others; and
iii) Scheme of delegation to officers.

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

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

2.1 Chair's action on urgent matters

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

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

2.2 Delegation of Board functions

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

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

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

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may

periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

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

Use of the term 'Committee'

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

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

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

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

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

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

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

Joint Committee Standing Orders, terms of reference and operating arrangements

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

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

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

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

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

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

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

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

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

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

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

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

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

Full details of the Committee structure established by the Board, including

detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

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

3.6 Confidentiality

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

3.7 Reporting activity to the Board

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

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

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

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

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

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

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

5.2 Support to the Advisory Groups

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

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

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

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

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

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

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report

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

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

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

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

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

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

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

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

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

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

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's

membership of the Board as an Associate Member.

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

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

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

5.8 Relationship between the SRG and others

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

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

5.9 Working with Llais

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

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

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

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional

perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

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

5.12 Relationship with the Board

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

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

5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

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

5.13 Rights of Access to the LHB Board for Professional Groups

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

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

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

5.14 Relationship with the National Professional Advisory Group

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

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

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

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

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

5.16 Relationship with the Board and others

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

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

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

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

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and

other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

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

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

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

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

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

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

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

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

6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and

- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

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

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

Relationship with the Board

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

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

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

7. MEETINGS

7.1 Putting Citizens first

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

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

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

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

7.2 Annual Plan of Board Business

7.2.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to

meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

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

The notice shall state that:

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

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

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

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance/Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of

Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance/Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days ~~10 calendar days~~ before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance/Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the

time and place of the meeting, ~~and the public part of the agenda,~~ shall be displayed bilingually (in English and Welsh):

- On the LHB's website, ~~together with the papers supporting the public part of the Agenda~~; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

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

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

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

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

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

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

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

Addressing the Board, its Committees and Advisory Groups

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

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance/Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may

participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance/Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.,

the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

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

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

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

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

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

Voting

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

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

LHB's Advisory Groups and the Llais representative(s).

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

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

7.6 Record of Proceedings

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

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

7.7 Confidentiality

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

8. VALUES AND STANDARDS OF BEHAVIOUR

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

8.1 Declaring and recording Board members' interests

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

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance/Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance/Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Director of Corporate Governance/Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance/Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance/Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance/Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance/Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance/Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The

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

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

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

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

8.3 Dealing with officers' interests

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

8.4 Reviewing how Interests are handled

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

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework **[LHB to insert title of relevant policy]** approved by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

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

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

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition, gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Standards of Business Conduct Policy** and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance/Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB;

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

- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Director of Corporate Governance/Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

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

9.2 Signature of Documents

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

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

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Director of

Corporate Governance/Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by the National Health Service Wales Joint Commissioning Committee (the JCC) shall be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

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

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board,

facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

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

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

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

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

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

10.3 External Assurance

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

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

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

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

11. DEMONSTRATING ACCOUNTABILITY

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

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

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

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

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

12. REVIEW OF STANDING ORDERS

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

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

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

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

i) A Committee, e.g., Quality and Safety Committee;

ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

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

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

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

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

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

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

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

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

The Board

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

The Chief Executive

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

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

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

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

The Director of Corporate Governance/Board Secretary

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

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

The Audit[4] Committee

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

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

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

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

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

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

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

SCHEDULE OF MATTERS RESERVED TO THE BOARD[5]

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

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

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

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

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

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

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

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

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

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

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

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

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

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

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

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

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

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[6] As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

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

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

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

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

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

LHB framework

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

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

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

These documents may be accessed by:

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

NHS Wales framework

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

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

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

[please see separate Schedule 2.1 for SFIs]

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

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

Terms of Reference available for all Committees on the Health Board website

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

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

Schedule 4.1 – National Health Services Joint Commissioning Committee

Appendix A, Document 2: Standing Orders for the NHS Wales Joint Commissioning Committee

Appendix A, Document 3: Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee

Appendix B, Document 1: Standing Financial Instructions for the NHS Wales Joint Commissioning Committee

Appendix C: Accountability Map

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

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

Terms of Reference available for all Advisory Groups on the Health Board website

Schedule 5.1

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

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

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

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

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

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

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

1.2 Membership

1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including

remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

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

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

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

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

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

1.3 Member Responsibilities and Accountability:

The Chair

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

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

Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

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

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

The Vice Chair

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

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

Members

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

1.3.7 All members must:

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

1.3.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or

grouping for the way in which they represent the views of their body or grouping at the SRG.

1.4 Appointment and terms of office

1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

1.4.3 The Director of Corporate Governance/Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

1.4.5 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

1.4.7 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB

Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

1.4.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5 Resignation, suspension and removal of members

1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

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

1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

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

1.5.5 Before making a decision to remove a person from office, the Board may

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

1.6 Relationship with the Board

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

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

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

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

1.7 Relationship between the SRG and others

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

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

1.8 Working with Llais

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

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

Schedule 5.2

Health Professionals' Forum

Terms of Reference and Operating Arrangements

THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

1.1 Role

1.1.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

1.1.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

1.2 Terms of reference and operating arrangements

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

1.3 Membership

1.3.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative
- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative
- Welsh Therapies Advisory Committee
  - Therapies representative
- Welsh Scientific Advisory Committee
  - Scientific representative

- Welsh Optometric Committee
  - Optometry representative

- Welsh Dental Committee
  - Dental representative

- Welsh Pharmaceutical Committee
  - Hospital Pharmacists representative
  - Community Pharmacists representative

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

1.4 Member Responsibilities and Accountability:

The Chair

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

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

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

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

The Vice Chair

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

of Associate Member of the LHB Board.

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

Members

1.4.6 The HPF shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the HPF.

1.4.7 All members must:

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

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

1.5 Appointment and terms of office

1.5.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

1.5.2 The ***Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the

Regulations.

1.5.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.

1.5.4 The ***Vice Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.5.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.

1.5.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.

1.5.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

1.6 Resignation, suspension and removal of members

1.6.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.

1.6.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the HPF

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

1.6.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.6.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

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

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

1.7 Relationship with the Board

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

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

1.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

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

1.8 Rights of Access to the LHB Board for Professional Groups

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

i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or

ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

1.8.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

1.9 Relationship with the National Professional Advisory Group

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

Schedule 5.3

Local Partnership Forum Advisory Group
Terms of Reference and Operating Arrangements

1.1 Role and Purpose

1.1.1 The LHB Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

1.1.2 At the earliest opportunity, the Board will engage with staff organisations in the key discussions at the LHB Board, LPF and Locality/Divisional level.

1.1.3 All members are full and equal members of the forum and collectively share responsibility for the decisions made.

1.1.4 The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

1.1.5 The purpose of the LPF will be to:

- Establish a regular and formal dialogue between the Board's Executive and staff organisations on matters relating to workforce and health service issues.
- Enable employers and staff organisations to put forward issues affecting the workforce.
- Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.
- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.

- Appraise and discuss in partnership the Board services and activity and its implications.

- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.

- Communicate to the partners the key decisions taken by the Board and senior management.

- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Board including matters of service re-profiling.

- Negotiate on matters subject to local determination.

- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties

- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

1.1.6 In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the LHB LPF.

1.2 General Principles

1.2.1 The LHB and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

1.2.2 The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency
- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline they represent.

1.2.3 A Code of Conduct is attached as Appendix 2.

1.3 Membership

1.3.1 All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the LHB recognises for collective bargaining. The Trade Union member of the LHB Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

1.3.2 Management will normally consist of the following members of management representatives:

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

1.3.3 Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

Staff Representatives

1.3.4 The Board recognises those staff organisations listed in Appendix 3 for the representation of members who are employed by the organisation.

1.3.5 Staff representatives must be employed by the organisation and accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

1.3.6 Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

1.4 Quorum

1.4.1 Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.

1.4.2 If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.

1.4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

1.5 Officers

1.5.1 The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

1.6 Chairs

1.6.1 The Management and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups. Supported by the Director of Corporate Governance/Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.7 Joint Secretaries

1.7.1 Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

1.7.2 The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

1.8 Sub Committees

1.8.1 When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

1.9 Management of Meetings

1.9.1 Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

1.9.2 The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Board wide strategic issues and issues that have LHB wide implications shall be referred to the Welsh Partnership Forum via the LHB Board.

1.9.3 The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

1.9.4 The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid ‘put downs’ of views or points made by colleagues
- Respect a colleague’s point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No ‘side-meetings’ to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as ‘staff organisations’ within these Standing Orders

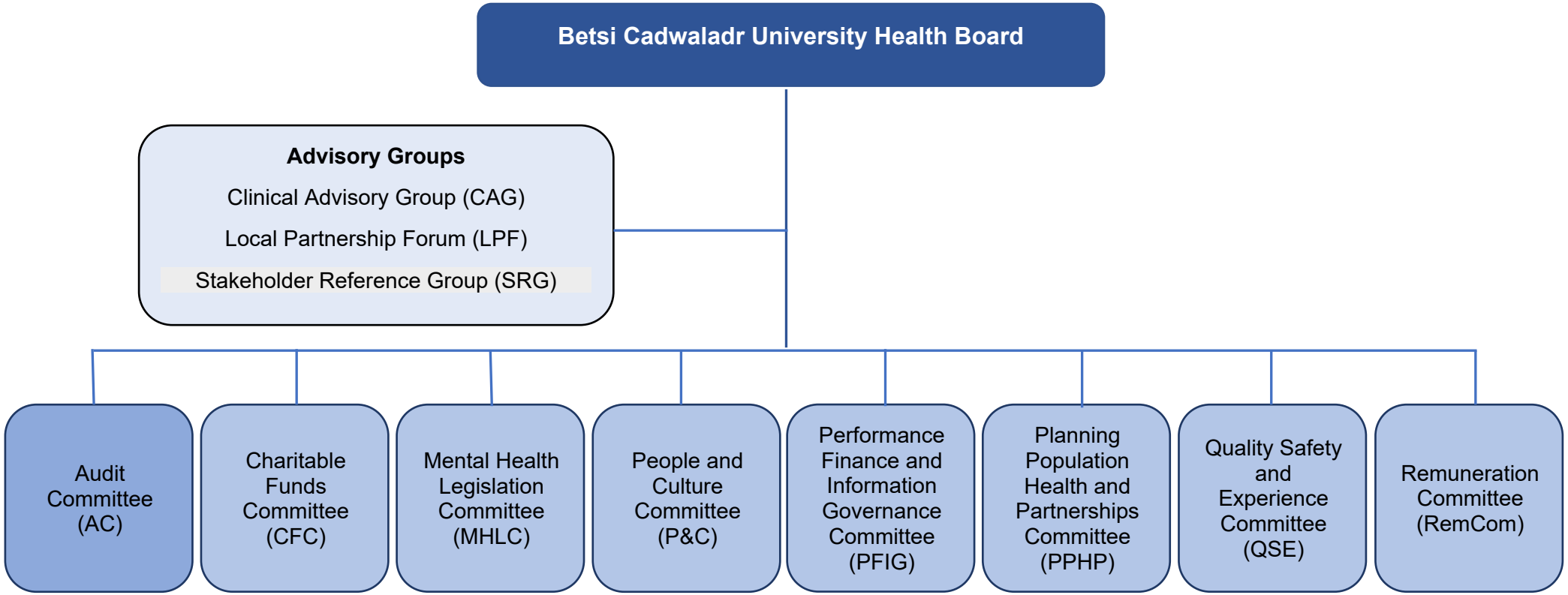
- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

AUDIT COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

Date approved by Health Board:



Version Control

Version	Issued to	Date	Comments
V0.01			

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

2.1 The purpose of the Committee is to act on behalf of the Board to:

2.1.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.1.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.

2.1.3 Where appropriate, advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.1.4 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

2.1.5 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

2.1.6 Work with all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.

2.1.7 Receive assurance on delivery against relevant Planning Objectives aligned to the Committee in accordance with Board approved timescales, as set out in BCUHB's Annual Plan.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Audit Committee will comment specifically upon:

3.1 Governance, Risk Management and Internal Control

3.1.1 The Committee shall review the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives and designed to support the public disclosure statements that flow from the assurance processes, including the Accountability Reports.

This includes:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government, the NHS Wales Executive and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens.

3.1.2 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, together with any accompanying Head of Internal Audit documents and opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.1.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.1.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and

that the effectiveness of that framework is regularly reviewed.

3.1.6 The Committee will monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.

3.1.7 The Committee will also seek assurance on delivery against Integrated Medium Term Plan Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.

3.1.8 The Committee will consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework (BAF).

3.1.9 The Committee will be responsible for reviewing the Health Board's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

3.1.10 The Committee will receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the Health Board and report to the Board the adequacy of these arrangements.

3.1.11 It will also review and report to the Board annually the arrangements for declaring, registering, and handling interests.

3.1.12 The Committee will approve the writing-off of losses or the making of special payments within delegated limits.

3.1.13 The Committee will also receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.

3.1.14 The Committee will receive a report on all Single Tender Actions and extensions of contracts.

3.2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective internal audit (including of the capital / PFI function) established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- reviewing and approving the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- reviewing the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;

- regular consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit safety;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- an annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications of, and management's responses to, its work. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- discussion with the External Auditor on its local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- reviewing all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- reviewing progress against the recommendations of the annual Structured Assessment.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.4.2 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies is brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.4.3 The Audit Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

3.4.4 The Audit Committee will also seek assurances where a significant activity is shared with another organisation(s), in particular the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and other regional committees. The Audit Committee will expect to receive assurances from internal audit performed at these organisations that risks

in the services provided to them are adequately managed and mitigated with appropriate controls.

3.5 Management

3.5.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.5.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

3.5.3 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

3.5.4 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:

- the ISA 260 report to those charged with governance;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- significant adjustments resulting from the audit;
- other financial considerations include review of the Schedule of Losses and Compensation; and
- the Management Letter of Representation to the External Auditors.

3.5.5 The Audit Committee shall prepare an Annual Report to the Board, timed to support the preparation of the Annual Governance Statement. The report should include, as a minimum, specific statements confirming that:

- the draft Annual Governance Statement is consistent with the view of the Committee on the organisation's system of internal control and that it supports the Board's approval of the Statement, subject to any reasonable limitations that the Committee wishes to draw to the attention of the Board;
- the system of risk management in the organisation is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks;
- the Committee has reviewed the system of assurance, and believes that it is fit for purpose;
- there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been adequately resolved; and
- the current self-assessment by the organisation against the relevant risk management standards is consistent with the Committee's understanding, gained through its assurance work.

3.5.6 The Committee shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.5.7 The Committee should also ensure the provision of an effective Counter Fraud service that meets the standards set for the provision of Counter Fraud in the NHS in Wales

and provides appropriate assurance to the Board and the Accountable Officer through the Committee.

3.5.8 The Committee should assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair) NB: At least one of the two Independent Members should be a member of the Quality, Safety & Experience Committee

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)
Director of Corporate Governance
Other Attendees
Other Executive Directors as required by the Chair
Other Senior Managers as required by the Chair
Head of Internal Audit
Head / Individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of Auditor General (External Audit)

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills

and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Finance at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of

any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business and
- Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

• Quorum

11. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that

any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Teitl adroddiad: ***Report title:***	**Conformance Report: Q3 2024/25**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 04 March 2025
Crynodeb Gweithredol: ***Executive Summary:***	This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations. The areas covered in this report are: • **Purchase orders that are non-compliant with SFI's (October to December 2024)** This data set relates to orders being raised after the invoice has been received. Non-compliance for the period is 245 in October, 336 in November and 214 in December 2024. The total 795 breaches during quarter 3 (Q3) is a material improvement compared to 964 in Q3 2023-24. A significant proportion of the orders are for known expenditure such as utilities charges, out of area treatments and Royal Mail postal collections however, the variable nature of the volume means that retrospective orders are produced. The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Oracle IProc Refresher training sessions has been offered during quarter 3, with three sessions in October and 1 in December 2024 collectively attended by over 500 staff. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales. NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD). During Quarter 3, the number of file notes approved was 10 with a total contract value of £3.3m. • **Single Waivers (October to December 2024)** The number of waivers issued year to date has significantly decreased compared to this period last year. Single Tenders – 11 approved in Q3, compared to 6 last year. Single Quote – 0 approved in Q3, compared to 3 last year. • **Receivables and conformance with payroll procedures** The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 31st December 2024, there were 3,307 outstanding invoices, totalling £12.9m, of which 601 invoices, totalling £7.5m were less than 30 days old.

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

For the period October to December 2024 there were 114 staff overpayments, with a gross value of £0.295m, comparable to 70 and £0.144m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (100 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 31st December 2024 the balance outstanding was £1.117m, compared to £1.087m 30th November 2023.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

  The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The year to date achievement for non-NHS invoices by number is 96%.

- **Losses and special payments**

  Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

  Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

  Clinical negligence claims are managed by Legal and Risk Services and there were 307 active claims at the end of December 2024. Of these 143 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £162m (before reimbursement from the Welsh Risk Pool).

- **Welsh Risk Pool Penalties – Learning from Events Report**
  Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

  As at 31st December 2024 the number of claims outstanding is 86.

- **Chairs Action in Quarter 3 2024/25**
  There were no Chairs actions in relation to financial compliance during the period.

	• **Contract Procurement Review Update** ○ Financial Procedures - Further significant progress has been made during the last quarter with 11 procedures completed and approved by the Executive Director of Finance. 6 of the outstanding policies / procedures are nearing completion and 2 new procedures (on budgets and virements) have also been written and are at the consultation stage. The risk associated with the outdated procedures is considered low. The completion date is end of March 25. ○ Contract Register – The finance systems team and finance team are working in partnership with an external software solutions company to scope a Pan-BCU document and records management system for contracts using Microsoft SharePoint.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: 1. To note and discuss the below elements of performance • Purchase orders that are non-compliant with SFI's • E-Waiver System Developments and Single Waivers • Receivables and conformance with payroll procedures • Payables and conformance with Public Sector Payment Policy (PSPP) • Welsh Risk Pool Penalties – Learning from Events Report • Contract Procurement Review Update 2. Approve the Losses and Special Payments (October to December 2024)
Arweinydd Gweithredol: ***Executive Lead:***	Russel Caldicott, Interim Executive Director of Finance
Awdur yr Adroddiad: ***Report Author:***	Denise Roberts, Head of Capital, Business Improvement and Compliance

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose.

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Management of financial risk of not achieving value for money.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** • ***The report is for noting and, in the case of losses and special payments, approval***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Appendix 1: Conformance Report – Quarter 3 (October to December 2024) 2. Appendix 2: Approved Single Tender Waivers between 1st October – 31st December 2024	

Appendix 1 : Conformance Report – Quarter 3 (October to December 2024).

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

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

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

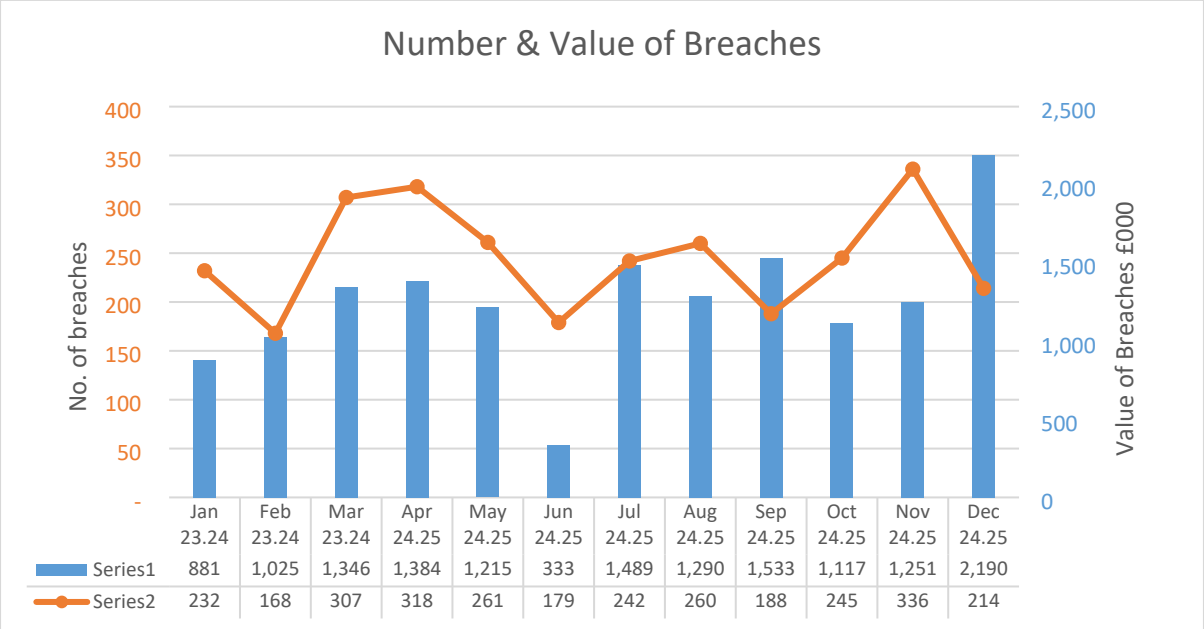
*Exemptions apply (see SFIs)

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

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been an 8% increase in the value of Purchase Order breaches in quarter 3 (Q3), with 795 breaches reported with a value of £4.6m. During the same period last Financial Year, the number of breaches were 964 with a value of £5.2m.

The value and number of breaches between January and December 2024 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q3 are as follows:

Division	Month of Breach	Item Description	PO Amount £000's
Utilities & Rates	Dec-24	01/10/2024-31/10/2024 ELECTRIC CHARGES FOR ACCOUNT NUMBER 9888114523	267
Utilities & Rates	Dec-24	01/11/2024-30/11/2024 ELECTRIC CHARGES 9888114523	260
East Area	Dec-24	GP OOH SERVICE ADVANCED BUSINESS SOFTWARE	249
WF&OD Executive	Dec-24	SLA FOR GUARDING PROVISION FOR THE ACUTE SITES FROM 01/08/24 -01/02/25	231
Utilities & Rates	Dec-24	01/10/2024-31/10/2024 ELECTRICITY INVOICE	222

The Divisions with the highest number of PO breaches have been listed below (£'000s):

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
East	111	62	101	119	86	70	75	86	64	76	94	55	725
Centre	49	37	68	83	64	39	57	126	40	74	108	63	654
West	17	30	43	51	51	40	62	93	40	80	87	75	579
Mental Health & LDS	23	27	48	27	37	19	26	35	17	25	31	20	237
Regional Services	29	14	23	27	38	24	17	36	25	22	33	20	242

Expenditure Type	Q1	Q2	Q3
Pay (Agency, Fees etc)	494,397	279,110	307,865
Managed Practices	129,987	136,041	115,372
Non-Pay	2,307,822	3,896,810	4,134,814
Total	**2,932,206**	**4,311,961**	**4,558,051**

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

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

In addition, Oracle IProc Refresher training sessions are being rolled out in partnership between NWSSP and the Health Board to ensure a better understanding of the processes. Oracle IProc Refresher training sessions has been offered during quarter 3, with three sessions in October 24 and 1 in December 24 collectively attended by over 500 staff.

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

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 3, the number of file notes approved was 10 with a total contract value of £3.3m. The table below provides detail for each file note:

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	Dept	Contract Period	Total Contract Value
2425-059-FN-BCU	CWMNI ADDYSG RHYW - SEX EDUCATION COMPANY	PROVISION OF C-CARD SCHEME IN NORTH WALES FOR AGES 13-25 - APRIL-SEPTEMBER FY 24/25	To cover department until contract is in place.	Community & Primary Care	ONE OFF	£19,206.00
2425-069-FN-BCU	DAYBREAK MEDICAL LTD	RENTAL OF ELLEX TANGO REFLEX & QUANTEL ABSOLU (17/04/2024 TO 16/04/2025)	Committed to the rental prior to order being raised - On the Capital med devices plan.	General Surgery	ONE OFF	£83,880.00
2425-070-FN-BCU	IMPACT MEDICAL LTD	HIRE OF MOBILE LITHOTRIPTER AND OPERATORS IN UROLOGY DEPARTMENT FOR 12 MONTH PERIOD FROM 01.08.24	Committed to the hire prior to order being raised	General Surgery	ONE OFF	£24,000.00
2425-071-FN-BCU	RADIOLOGY MANGEMENT SOLUTIONS LTD	STAFFING FOR THE CT AND MRI SCANNER	Extension of existing contract without appropriate authorisation	Radiology	12 MONTHS	£2,870,000.00
2425-081-FN-BCU	SCAN ASSURE	STAFFING FOR THE CT AND MRI SCANNER	Extension of existing contract without appropriate authorisation	Radiology	9 MONTHS	£176,000.00
2425-086-FN-BCU	BRADLEYS GP PRACTICE	MEDICAL COVER AT MARLEYFIELD RESIDENTIAL CARE HOME	Change implemented without Executive Approval	Community Services	12 MONTHS	£24,800.00
2425-093-FN-BCU	TREE VIEW DESIGNS LTD	Websites Annual Support for the 12 health board practices	Placed on Oracle with Retrospective dates	ICT	12 MONTHS	£9,480.00
2425-097-FN-BCU	ROYAL MAIL GROUP PLC	WEEKLY POSTAL COLLECTIONS INVOICE 9071884585	Order raised retrospectively	ICT	ONE OFF	£36,149.09
2425-102-FN-BCU	MARGDEN HEATING	PIPEWORK MODIFICATION	Awaiting approval of waiver to complete urgent boiler replacement	Estates	ONE OFF	£11,618.40
2425-103-FN-BCU	NATIONWIDE BOILER HIRE	TEMPORARY BOILER HIRE	Awaiting approval of waiver to complete urgent boiler replacement	Estates	4 WEEKS	£9,305.00

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

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

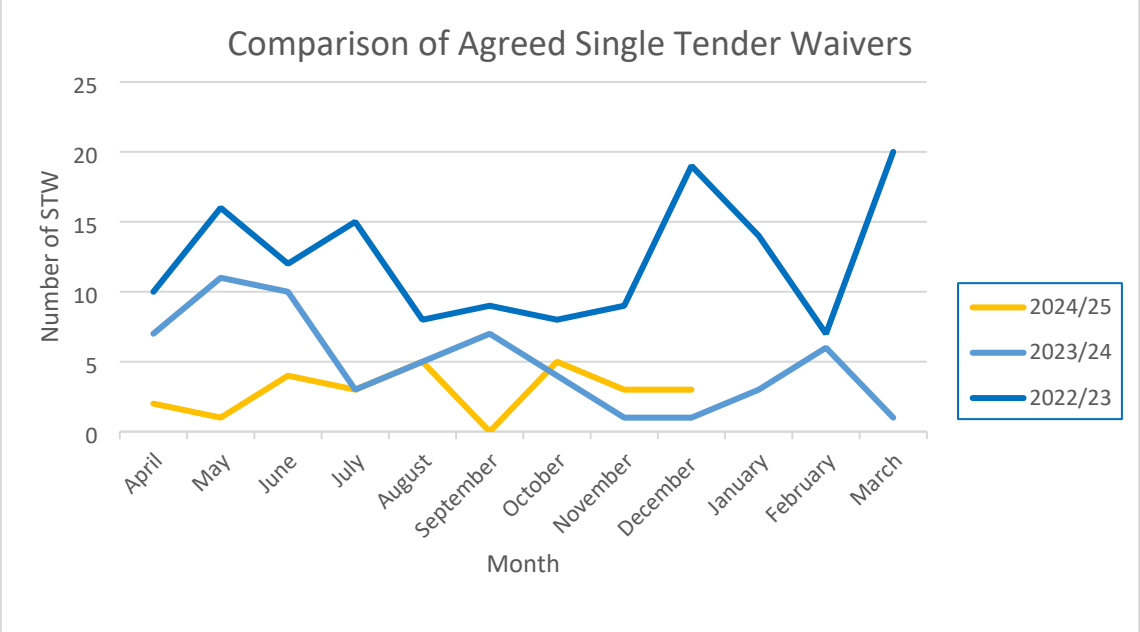
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause;
- A need to retain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

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

Single Tender Waivers	2023-24 Q3	2023-24 FYE	2024-25 Q3	2024-25 YTD
Waivers Issued	8	100	11	31
Waivers Approved	6	59	11	26
Value of Approved Waivers	£0.6m	£4.5m	£1.8m	£2.8m
Waivers approval above EU Threshold	2	8	1	1
Cancelled Waivers	1	13	3	6

The number of approved waivers has increased in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 1**.



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

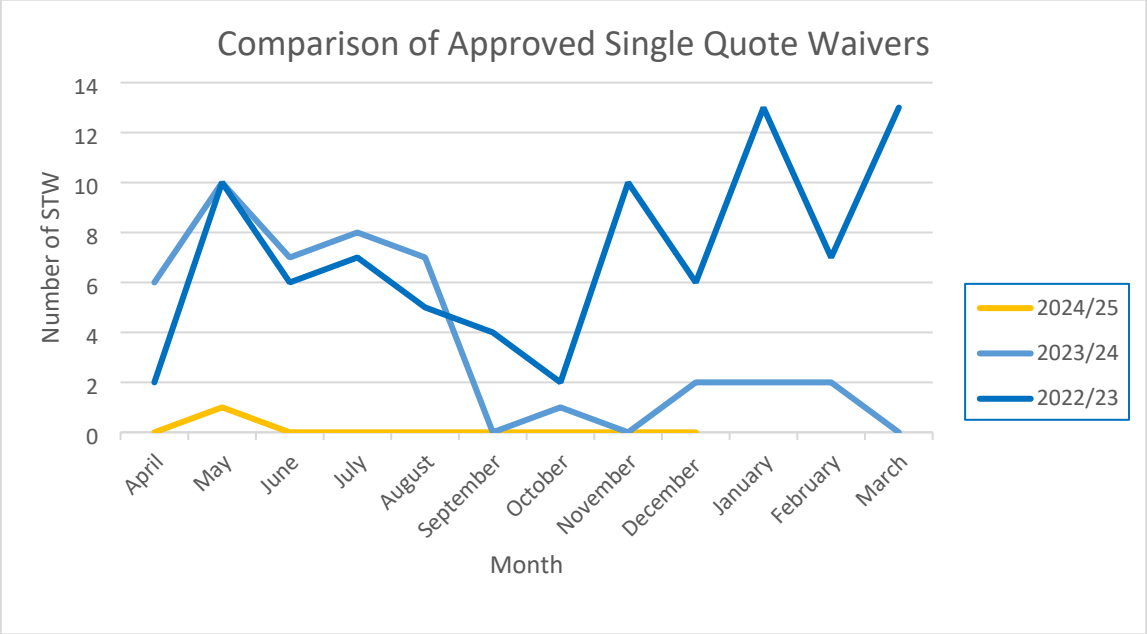
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

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

Single Quote Waiver	2023-24 Q3	2023-24 FYE	2024-25 Q3	2024-25 YTD
Waivers Issued	11	94	13	49
Waivers Approved	3	45	0	1
Value of Approved Waivers	£0.06m	£0.59m	£0.00m	£0.07m
Cancelled Waivers	2	10	0	0

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

The chart below provides a summary of the approvals to waive quote requirements for 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 2**.



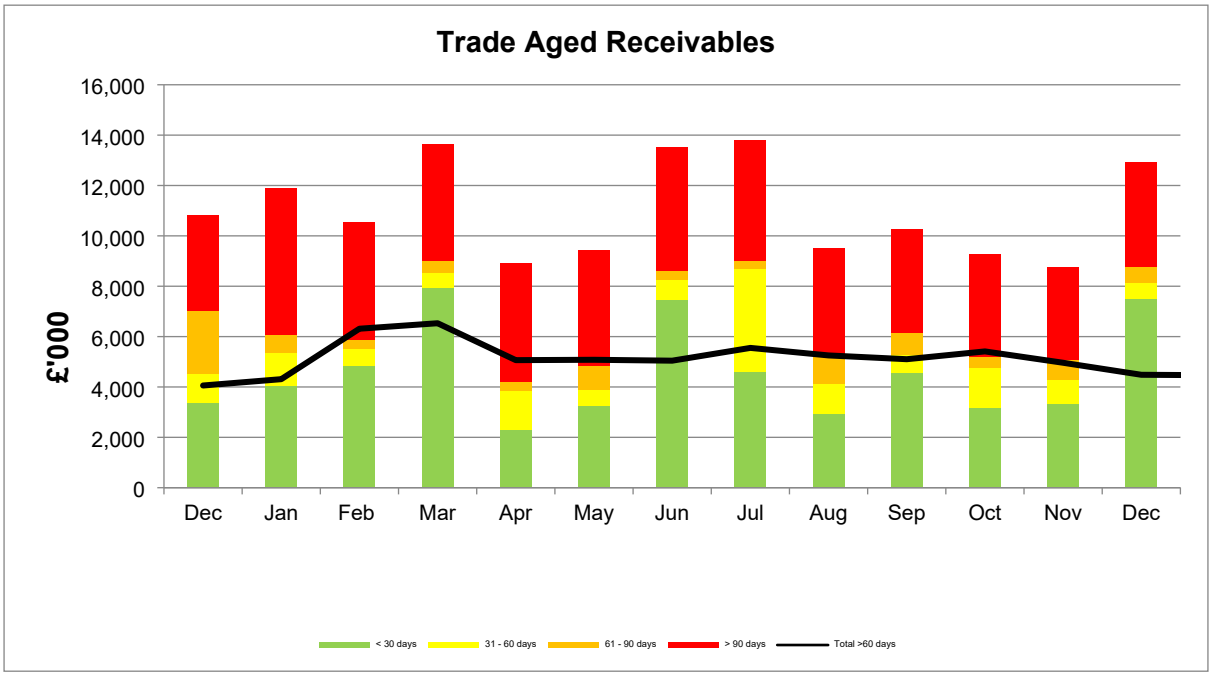
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

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

As at 31st December 2024, there were 3,307 outstanding invoices, totalling £12.9m, of which 601 invoices, totalling £7.5m were less than 30 days old.

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



Provisions for bad and doubtful debts

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

Receivable balances over £10,000 and in excess of 6 months old as at 30th June 2024

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

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
The Walton Centre	188	9	All queries were responded to by Income, Walton are refusing to clear these invoices due to another dispute they have with BCU owing them £162k.	Apr 22 to Mar 24
St Helens & Knowsley Hospitals NHS Trust	97	1	Invoice is in dispute, currently being looked into by NHS England and the head of the Northwest Lead Employer Deanery. FD followed this up with the Trust 17/10.	Sep-22
NHS Cheshire and Merseyside ICB	88	4	Charges were queried by debtor, BCU has responded with evidence to support the charge in November 24, followed up in January 25.	Oct 23 to Apr 24
Connah' s Quay Primary Care Resource Centre Management Co Ltd	58	1	Invoice has been chased several times with payable team, Account Receivable are now liaising with surgery manager for payment date. Followed up in January 25.	Mar-24
Salary Overpayment	39	1	Workforce have just responded to final query and explained that payment should be made immediately, if no payment received by end of January 25 the debt will be referred to CCI.	Dec-23
Sunderland GP Alliance	29	1	Charge for clinical trial, dispute over who should have been invoiced but correct company has gone into Administration - seeking authorisation to write off invoice.	May-24
Overseas Visitor Charge	28	1	Charge for inpatient - referred to CCI. This case was transferred to the international collection team who are in the process of trying to locate the debtor and encourage payment.	Sep-22
Salary Overpayment	26	1	Debtor contesting the invoice which was investigated, debtor now supplied with evidence invoice is correct and repayment method currently being agreed.	Jul-23
NHS South West London ICB	22	1	Chased several times, various contacts within NHS South West London but no response. Next step is to liaise with NCA team for additional contact details.	Jan-23
Overseas Visitor Charge	20	1	Debtor with CCI, this case was transferred to the international collection team who are in the process of trying to locate the debtor and encourage payment.	Aug-22
Denbighshire CC	20	1	Seeking approval for this invoice to be written off as Denbighshire CC confirmed that debt is not due and have removed from their ledger, service cannot supply enough evidence to support claim.	Mar-20
Spirit Health Care Ltd	20	1	Query with an invoice BCU owed debtor so withholding payment - this has now been resolved and payment should be released.	Jun-24

NHS Greater Manchester ICB	17	1	After a dispute with invoice being placed on hold, we are now being told that payment must be authorised by somebody that is currently on leave. Will continue to chase.	Oct-23
Private Patient Charge	16	1	Charge for inpatient treatment, the invoice has been referred to the patient's insurance company and chased several times, due to contracts in place with the insurance company CCI referral is not possible.	Jun-22
NHS Shropshire Telford and Wrekin ICB	16	1	Invoice was disputed due to query around contract. Income team advised debtor LAC invoices do not form part of a contract so invoice should now be released for payment.	Oct-23
Salary Overpayment	16	1	Was with Workforce, meetings held to agree a way forward however employee is still disputing. Workforce discussing a way forward.	Feb-22
Salary Overpayment	14	1	Debtor with CCI who are proceeding with their collection efforts.	Jan-22
Salary Overpayment	13	1	The debtor is querying this invoice, payroll is looking into query - Accounts Receivable have chased payroll a number of times for a response. Next step to escalate to senior management.	Feb-24
Salary Overpayment	12	1	Debtor referred to CCI external debt collection who are liaising with debtor to prompt payment.	Nov-23
Salary Overpayment	12	1	Debtor with CCI external debt collection who are liaising with debtor to prompt payment.	Nov-23
NHS Commissioning Board	12	1	No response from various contacts chased - Escalating to Income for additional support with chasing.	Jun-24
Private Patient Charge	10	1	Charge for inpatient treatment, the invoice has been referred to the patient's insurance company. Accounts Receivable working with insurance to obtain payment, contract restraints are not making it possible to refer to CCI.	Oct-20
Q3 Total Q2 Total Q1 Total Movement in current quarter	1,230 1,061 1,602 169	40 38 43 2		

- *St David's Hospice - Agreed repayment plan over a 3-year period, 1st instalment is due 31st March 2025*

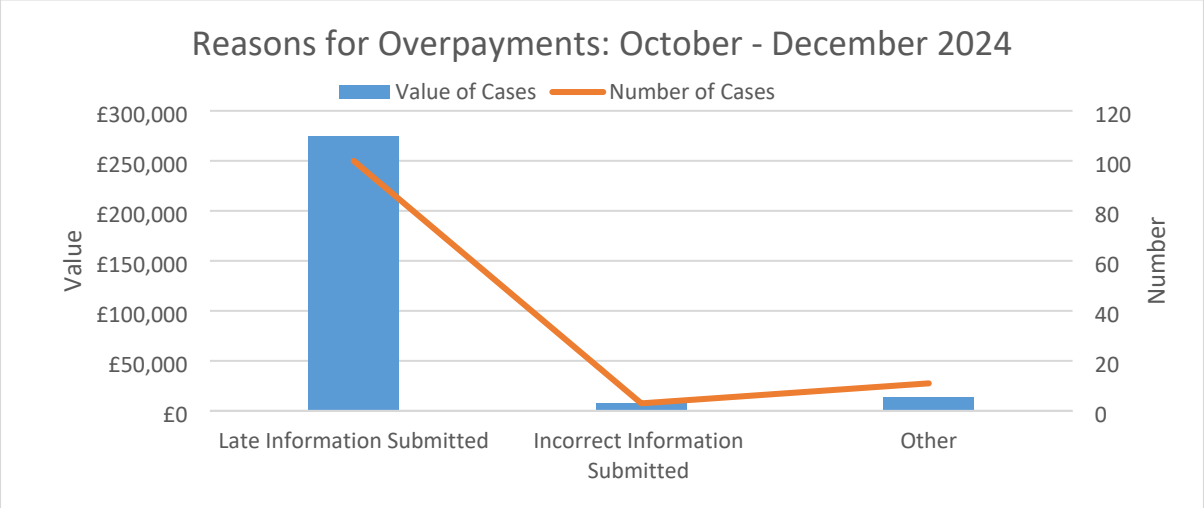
b) Staff Overpayments

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

	2023/24 Q3	2023/24 FYE	2024/25 Q3	2024/25 YTD
Number of Salary Overpayments	70	482	114	387
Value of Salary Overpayments	£0.144m	£1.216m	£0.295m	£0.916m

For the period October to December 2024 there were 114 staff overpayments, with a gross value of £0.295m, comparable to 70 and £0.144m in the previous Financial Year.

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



The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

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

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

Staff Overpayment Repayments

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

As at 31st December 2024 the balance outstanding was £1.117m (30th September 2024 £1.127m). The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	232	34%	£0.313m
Collection Agents	286	42%	£0.413m
In Dispute or Under Review	86	13%	£0.253m
Reminder Stage	30	4%	£0.044m
Invoice Stage	39	6%	£0.093m

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

The extremely aged debts are there because either:

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

NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

Section 3 - Conformance with Losses and Special Payments Procedures

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

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

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 307 active claims at the end of December 2024. Of these 143 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £162m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

53% of the caseload (164 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2024/25	56
2023/24	59
2022/23	51
2021/22	42
2020/21	39
2019/20	29
2018/19	14
2017/18	4
2016/17	3
2015/16	3
2014/15	2
2013/14	0
2011/12	1
2010/11	1
2009/10	2
2008/09	1
Total claims	**307**

Losses and Special Payments

	Q4 23/24 £	Q1 24/25 £	Q2 24/25 £	Q3 24/25 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	9,541,733	4,446,078	4,811,287	7,453,235	Payments were made on 164 cases, of which 13 came under the Redress Scheme.
WRPS Reclaim	(9,150,159)	(3,989,599)	(4,260,545)	(6,676,066)	
Net Cost	390,888	456,479	550,742	777,169	
Personal Injury					
Gross cost	77,848	53,115	81,719	44,898	Payments were made on 44 cases.
WRPS Reclaim	(16.306)	(406)	(984)	(0)	
Net cost	61,541	52,709	80,195	44,898	
Loss of cash	0	165	0	320	Cash went missing from ward safe, the ward manager has requested a change of code for the safe.
Debtors written off	15,009	0	41,440	-54	Debtors are only written off as a last resort, after all means of collection have been exhausted.
Loss or damage to equipment, property and stock	104,529	67,606	55,447	110,970	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board.
Ex-gratia payments	19,259	43,493	20,156	5,448	Relates to 5 payments for loss/damage of patient's property, 1 payment for ex-gratia payments and 6 ombudsman payments for delayed and unsatisfactory treatment.
VERS Payments	8,775	0	0	0	All payments are approved by the RATS Committee.
Total	**600,001**	**620,452**	**747,980**	**938,751**	

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

Section 4 – Welsh Risk Pool Penalties – Learning from Events Report

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

The Health Board has implemented a new process, approved by the Executive Team in December 2024. As part of the process, data is provided to divisions on a weekly basis to support local recovery of overdue submissions in real time with the aim of clearing the backlog position by the end of June 2025.

The Legal Service hold a bi-weekly meeting to support and scrutinise the divisions recovery efforts. Reported regularly to the WRP.

As at 31st December 2024 the total number of outstanding claims are 86. The claims, by category, are detailed below:

IHC/Division	Claims	Claims Deferred	Redress	Redress Deferred	Total
East	5	4	0	1	10
Central	22	9	6	2	39
West	1	5	0	0	6
MHLD	1	1	0	0	2
Womens	13	0	1	0	14
Diagnostics	0	1	0	0	1
Cancer	8	1	0	0	9
Dental	0	0	0	0	0
Corporate	4	1	0	0	5
Total	**54**	**22**	**7**	**3**	**86**

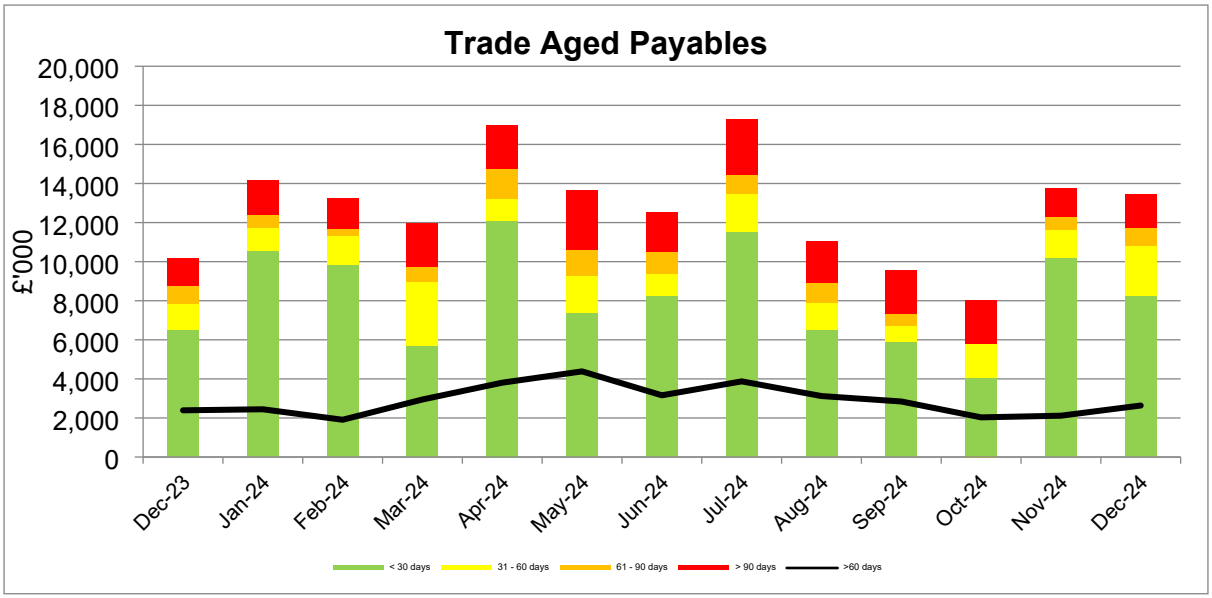
Section 5 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 96%.

High Value (£10,000 plus) Exceptions

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



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

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

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Linea Partners Ltd	245	12	Invoices have been formally disputed with the company; the Health Board has sought legal advice.	Jul - Oct 23
Omnicell Ltd	57	2	Requistioner has been requested to receipt PO or confirm if invoices are in query.	Jun 22 & Jun 24
Cygnet Healthcare Ltd	37	2	New PO has been raised as was against incorrect supplier, requisitioner has been email to request receipt.	Jun-24
Medtronic Ltd	35	2	PO quoted has been fully billed, requisitioner contacted to confirm if goods were received and if they were returned.	Mar 23 & Jan 24
Ontex Healthcare UK Ltd	29	1	New PO has been raised, emailed requisitioner to confirm as narrative on PO is different to the invoice.	Feb 24
Vale of Clwyd Mind	23	1	The funding for the service has moved, trying to identify new requisitioner/approver to enable invoice to be paid.	Jun-24
Abbott Medical Ltd	21	2	Price query raised; supplier has been asked for a part credit.	Jun-24
Johnson & Johnson Medical Ltd	21	2	End users have been requested to raise confirmation order or confirm if invoices are in dispute.	Jan & Mar 24
Cygnet Behavioural Health Ltd	16	1	New PO has been raised as was against incorrect supplier, requisitioner has been email to request receipt.	Jan-24
Cygnet Learning Disabilities Ltd	14	1	New PO has been raised as was against incorrect supplier, requisitioner has been email to request receipt.	Jun-24
Optima Medical Ltd	13	1	Part receipted, requisitioner contacted to find out if remaining amount can be receipted to enable payment.	May-24
Vantive Ltd	12	1	No PO quoted by supplier, department has been contacted to confirm PO number and receipt.	Apr-24
Becton Dickson UK Ltd	12	1	Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice.	Sep 22

Appendix 2 - Approved Single Tender Waivers >£25K between 1st October – 31st December 2024

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice	Finance Director Comments	Breached OJEU
2024/2025-1496	07/10/2024	Corporate	Red Whale	Purchase of primary care training for clinical workforce This is to purchase programme for autumn/ winter 2024. We offer annual programme of training for primary care staff. Been out for tender twice/unsuccessful as not meeting our requirements. Request for interim waiver until tender repeated.	Interim arrangement pending tender	£60,000.00	Accept	Procurement supports this single tender waiver request. Requirement tendered on two (2) occasions under BCU-OJEU-55140 & BCU-OJEU-56996, however those that bid could not meet the full requirement of the Health Boards Specification. A 6-month waiver is required whilst Procurement and the Primary Care Community Team review the Specification and Tender Documents before conducting a new tender for the Service.		No
2024/2025-1497	07/10/2024	Corporate	NB Medical	Purchase of primary care training for clinical workforce This is to purchase programme for autumn/ winter 2024. We offer annual programme of training for primary care staff. Been out for tender twice/unsuccessful as not meeting our requirements. Request for interim waiver until tender repeated.	Interim arrangement pending tender	£60,000.00	Accept	Procurement supports this single tender waiver request. Requirement tendered on two (2) occasions under BCU-OJEU-55140 & BCU-OJEU-56996, however those that bid could not meet the full requirement of the Health Boards Specification. A 6-month waiver is required whilst Procurement and the Primary Care Community Team review the Specification and Tender Documents before conducting a new tender for the Service.		No

2024/2025-1499	07/10/2024	Corporate	Rotherham Respiratory	Training courses for primary care workforce of Foundation, Advanced and Updates courses/range of levels for chronic disease training. Covers many different chronic disease topics i.e., asthma, COPD, at 3 levels of learning. Training very bespoke to GP Practices and needed for clinical planned care. Been out for tender twice/unsuccessful as not meeting our requirements. Request for interim waiver until tender repeated.	Interim arrangement pending tender	£60,000.00	Accept	Procurement supports this single tender waiver request. Requirement tendered on two (2) occasions under BCU-OJEU-55140 & BCU-OJEU-56996, however those that bid could not meet the full requirement of the Health Boards Specification. A 6-month waiver is required whilst Procurement and the Primary Care Community Team review the Specification and Tender Documents before conducting a new tender for the Service.		No
2024/2025-1502	25/10/2024	Secondary Care - Managed Clinical Support	Varian Medical Systems UK	Service Contract for four Linacs, inclusive of parts for a remaining period of two years for three machines. Due to age and status of the fourth machine only a one-year contract is being offered. Only Varian, as the company supplying the machines is able to offer a contract that includes replacements for faulty parts, or provide parts as part of local first line fault finding. Part of the contract is also escalation support and advice to local engineers. The cost for the second year is indexed to inflation, with a minimum of 1% increase. A contract with the same conditions is available through NHS SC, but at an increased cost of 2.5%	Genuinely one provider	£465,528.00	Accept	Procurement services support this waiver request based upon the sole supplier nature of servicing and parts element of the requirement. The NWSSP Maintenance Procurement team explored compliantly awarding this work through the NHS Supply Chain Framework. Unfortunately, the quotes issued through the framework provider offered increased cost pressures against the current agreement with Varian.		Yes
2024/2025-1506	31/10/2024	Capital	Kingsway Doors	Supply and installation of Anti-ligature door sets to deliver the MHLD priority requirements. Doors have been approved by service users and will integrate into existing patient alarm and access control systems	Compatibility Issue (e.g., warranty cover clause or specific equipment)	£774,157.00	Accept	Procurement Support the following waiver, going directly to Kingsway Doors offers the best value for money option to the Health Board. By going directly to the supplier, the Health Board have obtained a volume discount and removed the need to engage with a principal contractor, who would have charged an additional cost for the purchase and installation of the required doors.		No

2024/2025-1509	06/11/2024	Capital	Haemonetics	This quote is for a new HaemoBank 20 Refrigerator for the new Elective Orthopaedic Hub at Llandudno Hospital.	Compatibility Issue (e.g. warranty cover clause or specific equipment)	£35,203.00	Accept	Procurement supports this waiver request as this is specialist equipment required for the service and therefore alternatives cannot be considered. Framework research has been conducted; however, this equipment is not within scope and therefore a single tender waiver is the only option to progress this purchase.		No
2024/2025-1510	15/11/2024	Corporate	Cosmo Graphics,	Rebuilding missing patient records	Genuinely one provider	£61,425.50	Accept	Procurement supports this waiver on the basis that it is a sole supplier basis. Cosmo Graphics are the only provider that can re build the scanned batches previously sent to them. This will ensure they are not missing any patient records moving forward for when the systems change.		No
2024/2025-1513	21/11/2024	Capital	MPH Construction Ltd	Specialist enabling works associated with the replacement of the x-ray system at Alltwen Hospital. See attached breakdown. This project has approved WG funding for expenditure within 2024/25 along with 2 similar x-ray room replacements in Central IHC. The requirement is that 1 single contractor completes all 3 x-ray room replacements with 1 corresponding design and cost advisor team and liaises with the x-ray system suppliers. It would not be possible given the late provision of £1.451m of funding by WG within the financial year to operate 2 separate sets of contractors both in terms of resource, time and the risk of inaccuracies through duplication. Having 1 single contractor also represents best value. The Central BCUHB MTC framework does not allow for award outside of the Central area so it is proposed here that the Central MTC incumbent, MPH Construction, is awarded the Alltwen Hospital works via the separate CCS framework which allows for direct award. An STW is required to support a direct award under the CCS framework.	Genuinely one provider	£110,000.00	Accept	Procurement supports the waiver based on having one main contractor across all three sites which will ensure consistency and commonality of the work being undertaken. Although stated above the following is not a direct award via the CCS framework as this would incur an additional framework cost to the project and not provide the Health Board with the best value for money option. The submitted cost is in line with the rate received from the Central BCUHB MTC framework		No

2024/2025-1519	11/12/2024	Estates and Facilities	Margden Heating	Gas fired Boiler replacement.	Other (please specify) - Due to unforeseen circumstances there is an immediate and urgent need to undertake the replacement of failed boilers in MHLD at Wrexham Maelor.	£86,200.00	Accept	Procurement supports the following waiver due to the level of risk and the Health Boards ability to deliver services should the work not progress. Discussions took place between Operational Estates and Procurement Services where the advice given was to raise a waiver but to obtain 3 quotations from alternative suppliers to show that value for money is being achieved.		No
2024/2025-1520	09/12/2024	IHC East (Secondary Care - YWM)	Novel Biomarkers Catalyst Lab B.V.	IoPTH Analyser Proposal	Compatibility Issue (e.g., warranty cover clause or specific equipment)	£39,500.00	Accept	The Health Board have trialled this equipment extensively with their Pathology and Point of Care Testing teams. Capital funding has now become available to facilitate the equipment purchase. There are no frameworks available to purchase this device and the department are not able to consider alternatives due to the trial already undertaken. A single tender waiver is therefore the appropriate route on this occasion.		No
2024/2025-1522	17/12/2024	IHC Centre (Secondary Care - YGC)	Echosens	Fibroscan	Genuinely one provider	£85,020.00	Accept	Procurement accepts this waiver request as the Fibroscanner device is only available from Echosens. Framework research has been conducted but this device is not covered within the scope of any available frameworks due to its specialist nature.		No

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report 8 January 2025 – 14 February 2025 Internal Audit Plan 2025-26		
Adrodd i: ***Report to:***	Audit Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	4 March 2025		
Crynodeb Gweithredol: ***Executive Summary:***	<u>Progress report</u> The progress report is produced in accordance with: • the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. • the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report summarises four reviews finalised since the last Committee meeting in January 2025, with the recorded assurance as follows: • Reasonable assurance – three • Assurance rating not applied – one The report also includes information on draft reports issued and work in progress. <u>BCUHB Internal Audit Plan 2025-26</u> The audit plan for 2025-26 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. The Plan details the risk based planned audits for the year following a review of Board and Committee papers, Board Assurance Framework, Corporate Risk Register, meetings with Independent Members and Executive Directors, and reviews deferred from 2024-25.		
Argymhellion: ***Recommendations:***	The Committee is asked to: **Progress report** • Receive the progress report. **Plan** • Approve the Internal Audit Plan for 2025-26. • Approve the Internal Audit Mandate and Charter. • Note the associated Internal Audit resource requirements and Key Performance Indicators.		
Arweinydd Gweithredol: ***Executive Lead:***	Director of Corporate Governance		
Awdur yr Adroddiad: ***Report Author:***	Simon Cookson, Director of Audit & Assurance Services Nicola Jones, Deputy Head of Internal Audit, CMIIA		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting*	I Benderfynu arno *For Decision*	Am sicrwydd *For Assurance*

	☒	☒	☒
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan. The Health Board assurance ratings above differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. The audit plan for 2025-26 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 per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.

Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Progress Report is produced independently of management. The Progress report shared with the Director of Corporate Governance. Internal Audit plan shared with the Chief Executive, Associate Director of Governance, and Deputy Director for Legal Services.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The annual plan and progress report is presented according to the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Progress report • Appendix 2: Internal Audit Plan 2025-26 • Appendix 3: Final Internal Audit Report - Job Evaluation	

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

8 January 2025 to 17 February 2025

NWSSP Audit and Assurance Services

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

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

Contents

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.

Introduction

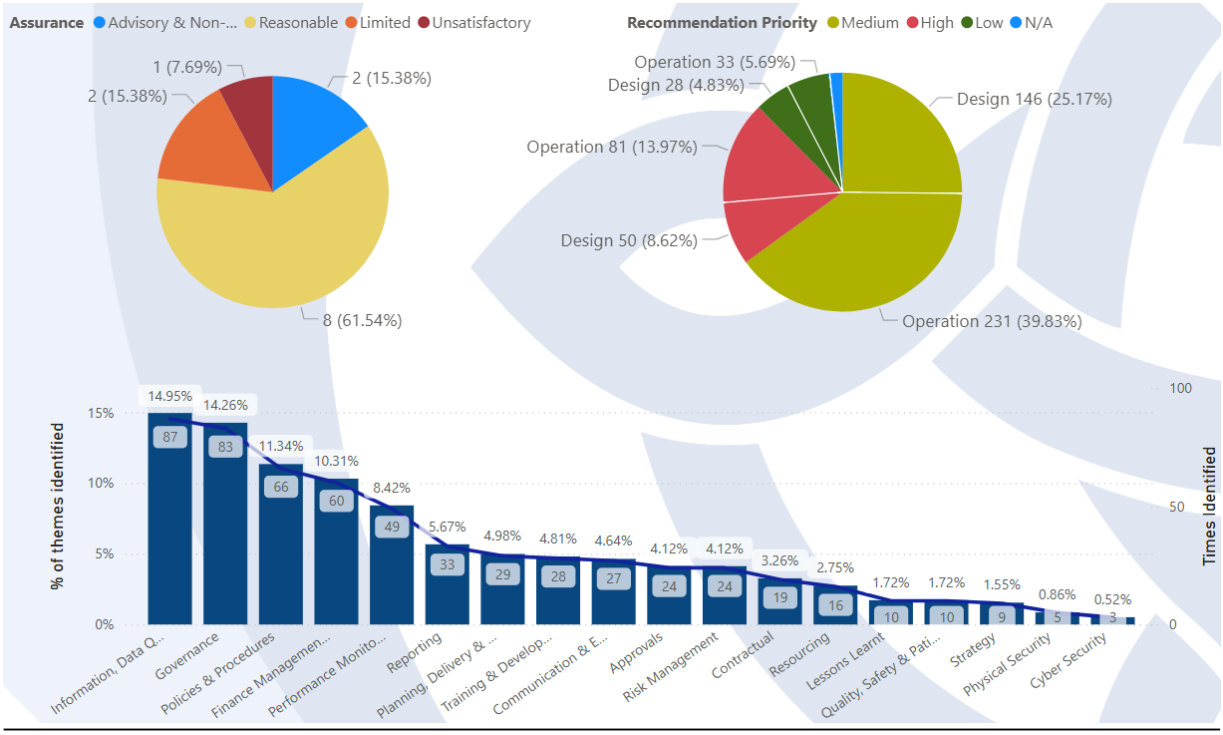
1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plans for 2024/25.

Reports Issued

2. Since the last progress report, four reviews have been issued as final.

3. The image below details draft and final report ratings to date, recommendations by priority and themes identified. This shows the key themes of recommendations to date relate to information, data quality and data accuracy; governance; policies & procedures; finance management and control and performance management.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as of 17 February 2025 – 2024/25 overview



- Theme definition is included at Table 6.

Executive Summaries

Network and Disaster Recovery	BCU-2425-12	16 January 2025
Report opinion:	Reasonable	

Purpose

To review the Health Board's 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.

Overview

We have concluded reasonable assurance on this area. The significant matters requiring management attention include:

- Although switches are covered by the patch process, there are a large number that were not patched to the latest, secure software version.
- We noted weaknesses in physical security, with a lack of identity checking and challenge and excessive access provided to digital areas within the door access management system.
- We noted some specific weaknesses in the environmental controls over Digital areas and datacentres.
- There is no planned, full testing of the resilience position or application failovers; without fully testing there is a risk that the provision does not work as anticipated.
- There is an absence of detailed technical recovery documents, with a reliance on restoration from backups.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- There is a replacement programme for equipment which includes servers, however switches are not specifically noted.
- There were many unpatched switches.
- There is no SOP that sets out how alerts will be managed which would enable new team members to undertake process.

Scope & Assurance Summary

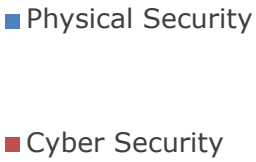
	Objectives	Related Findings	Assurance
1	The digital infrastructure is maintained with appropriate physical security, monitoring, support, and risk management in place.	-	**Reasonable**
2	The use of the network is managed to ensure stability, and capacity is appropriate for the organisation.	1	**Substantial**
3	Resilience is designed into the delivery of the technical infrastructure and applications ensure the designed resilience is used. Resilience is subject to testing at both infrastructure and application level to ensure that processes are operating as anticipated.	2, 3	**Reasonable**
4	An effective and tested recovery plan which meets the business requirements should be in place.	4, 5	**Reasonable**
5	Backups are taken appropriately, are tested and protected from unauthorised access and change to enable resilience.		**Substantial**

Management Actions

3
High Priority

2
Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Establishment Control	BCU-2425-15	21 January 2025
Report opinion:	Reasonable	

Purpose

To review the Establishment Control process and whether the Health Board is complying with Standing Financial Instruction 14.2 Funded Establishment. We have not reviewed the system and processes relating to recruitment as this will be subject to a separate review.

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- The Establishment Control Procedure has not been reviewed since 2018 and requires updating to incorporate the updated Standing Financial Instructions.
- As per roles and responsibilities within the Establishment Control Procedure 2018, the "Establishment Control & Finance Systems team quarterly audits" are currently not being undertaken.
- A review of a sample of Accountability Letters found one (of four) had not been agreed, as required by the Health Board's Standing Financial Instructions.
- Budget Manager e-learning has not been undertaken by all budget managers sampled in the review.
- There are variances between funded posts in the General Ledger and the establishment within the Electronic Staffing Record (ESR) system, suggesting the Health Board has approximately 390 Whole Time Equivalent (WTE) more vacancies than funded for.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	There is a procedure in place for establishment control that clearly outlines the process, responsibilities and monitoring / compliance of the process.	1,2	**Reasonable**
2	Establishment / budgets are communicated to operational areas and regularly reviewed by management.	3,4	**Reasonable**
3	Electronic Staff Record (ESR) staff in post figures are accurate and subject to regular validation.	5	**Limited**
4	Establishment Control activity has followed the steps outlined in the procedure, with appropriate systems and controls in place.	-	**Substantial**

5	The Enhanced Establishment Control Process has been followed for non-patient facing roles recruited since its implementation.	-	**Substantial**

Management Actions

2
High Priority

3
Medium Priority

Themes

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Job Evaluation	BCU-2425-32	24 January 2025
Report opinion:	Assurance rating not applied	

Purpose

To assess how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the Health Board.

Overview

We have not assigned an assurance rating for this review as the evidence required to undertake part of the review has not been provided by the Health Board and we advised officers of this on 5 December 2024.

The matters requiring management attention include:

- Job evaluation procedures do not comply with Scheme of Reservation and Delegation (SoRD) Matter 10e, which states only the Service Director can approve review/re-band requests. Allowing a Head of Service and Line manager to submit requests is a breach and must be corrected immediately to comply with the SoRD.
- Due to non-provision of evidence, we were unable to provide assurance that controls are embedded to ensure there are no conflicts of interest in job matching panels and that consistency checking is undertaken in line with procedures and the job evaluation handbook.
- The implementation of approved re-banding/review outcomes are not, in the main, being actioned by operational management in a timely manner. Establishment control and/or lack of funding should not become a barrier to timely implementation of formal outcomes, as current procedures do not require outcomes to progress through another control process.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion or internal control and are highlighted for management information:

- We note an Independent Member is listed as both matcher and consistency checker and there is a risk that this could lead to a perceived conflict of interest as a Member of the Board.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place, which set out the job evaluation process and promote fairness, consistency and equality for all members of staff.	1	**Reasonable**
2	Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	2, 3, 4, 5	**Not Completed**
3	Staff have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests.	-	**Substantial**
4	Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.	6	**Not Completed**

Management Actions

4
High Priority

2
Medium Priority

Themes

- Governance
- Policies & Procedures

Risk Types

Legal & Regulatory Non-Compliance

Financial Loss

Transformation & Improvement	BCU-2425-05	13 February 2025
Report opinion:	Reasonable	

Purpose

To review how the Transformation and Improvement Team have delivered on its purpose "…to support and enable the organisation to transform and improve itself."

Overview

By centralising teams with a remit for transformation and development, subtle obstacles that could have potentially impeded rather than increase team effectiveness have been removed. We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- There are costs allocated to the Transformation & Improvement (T&I) cost centre that are not applicable to the T&I team, which is impacting the overall financial position of the cost centre.
- We are unable to confirm the Transformation and Improvement team are subject to effective oversight through the reporting progress via the Health Board's governance structure on areas they are either supporting or accountable for, and whether changes made in transformation have made a difference.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Further development of tools and guidance for staff, and evidence of promotion of the services across areas.

Value Based Health Care and Special Measures have both recently been subject to separate audits (both rated reasonable assurance), so limited testing was undertaken relating to these areas of the Transformation and Improvement Team.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The structure and roles of the functions within the Team are in line with the funding, establishment and principles agreed by the Board.	1	**Reasonable**
2	The Team is providing their services to areas across the Health Board and promote use of transformation resource.	2	**Reasonable**
3	Progress and achievements are reported through to the Health Board via its Committees / Groups to provide assurance.	3	**Limited**

Management Actions

1

High Priority

2

Medium Priority

Themes

Risk Types

Quality or Safety Issues

Financial Loss

Work in Progress Summary

4. The following draft reports have been issued:

Table 1: Draft Reports issued

Review	Status	Date draft report issued	Management response due
Clinical Audit	Draft report issued – awaiting management response.	17 February 2025	17 March 2025

5. The following 2024/25 reviews are currently in progress:

Table 2: Reviews in progress

Review	Draft report due:
Discretionary capital funding allocation	February 2025 (fieldwork complete)
Standing Financial Instructions - Procurement	February 2025
Grievance Management	February / March 2025
Effective Governance – Cancer Services	February 2025
Effective Governance – IHC East	March 2025

Review	Draft report due:
Waiting List Initiative Payments – IHC Centre	March 2025
Performance Management Framework and Reporting	March 2025
Partnerships, Engagement and Communication	March 2025
Risk Management and Board Assurance Framework	April 2025
Orthopaedic Surgical Hub Llandudno Hospital (second audit)	March 2025

Follow Up

6. The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure.

7. We reviewed evidence provided for fifty-one (51) recommendations and actions. The status of these is:

   - Sixteen (16) are closed, with sufficient evidence provided.
   - Twenty-two (22) are partially closed, with some evidence provided.
   - Eleven (11) remain outstanding, where there was either no evidence or insufficient evidence provided.
   - Two (2) are currently subject to a separate review which is ongoing (Orthopaedic Surgical Hub Llandudno Hospital)

   Table 3 notes the recommendations closed and with internal audit comments. The Corporate Governance Directorate will liaise with Executives and managers to request further information for those partially closed or outstanding.

8. Table 3: Recommendations closed

Review Title	Audit Tracker Ref.	Recommendation Title	Audit Comments
Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	308	WG initiated, locally delivered tranche 'patient' validation exercise	Evidence provided to WPAS single system users to see all patient information. Unsure if evidence supports tighter controls regarding whether the Health Board now has a single integrated structure for patient administration, referrals, waiting list management, and removals management.
	309	WG initiated, locally delivered tranche 'patient' validation exercise	
	315	Patients removed from waiting lists	
	316	Patients removed from waiting lists	

Review Title	Audit Tracker Ref.	Recommendation Title	Audit Comments
Lessons Learnt	320	Lessons learnt – Policy	Confirmed PTR01 Integrated Concerns Policy has been approved by the Board and includes requirements for managing learning.
Water Safety	344	Risk Management	Management provided evidence that Welsh Water have attend YGC/YG and created a resilience plan which will be adopted on the YG site.
Deprivation of Liberty Safeguards	354	MCA Training levels 1 and 2 – awareness	Evidence provided for Mental Capacity Act materials delivered throughout the HB.
	355	MCA Training levels 1 and 2 – reporting	Evidence provided to support reporting of training information.
Discharge Arrangements	465	D2RA Performance Measures	Evidence confirms management update.
Health and Safety	487	Policies and Procedures	Health and Safety Policy revised and approved.
Roster Management	645	Policies and Procedures	Management provided evidence of an enhanced policy.
Risk Management	1269	Operational risk registers	Management provided evidence of Dashboard built to monitor track KPIs and communication with risk owners.
	1271	Corporate risk register	Management provided evidence of review of corporate risks.
Budgetary Control	1302	Budgetary control procedures	An updated Budget Holders Handbook was provided.
	1304	Delegated Limit changes	Management provided a Standard Operating Procedure for the variation to delegated limits within the Scheme of Reservation and Delegation and IHC / Division Procedures, this was operational July 2024 and to be reviewed July 2027.
	1305	Journal entries	Management provided a Standard Operating Procedure on the completion, upload and posting of journals, live from October 2024 and to be reviewed Sept 2027.

Contingency/Organisational Support/Advice

9. Internal Audit supports the Health Board through providing advice and guidance on

areas of control, new systems, and processes.

10. We meet regularly with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

Delivering the Plan

11. The additional support provided to the Health Board with focused reviews is channelled through contingency. As new risks are identified in year, the Director of Corporate Governance and internal audit will consider the planned reviews against the emerging high-level risks.

12. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5).

13. Table 4 is reporting a positive status across all indicators. Figures are based on eleven reports issued as final for 2024/25.

Table 4: Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	92%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]	Green	82%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5: Core Plan 2024-25

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Special Measures	June / July 2024	Final report issued.	Reasonable
Follow-Up of Internal Audit recommendations	April to September 2024	Completed – reported through progress report.	Not applicable
Transformation & Improvement	August / September 2024	Final report issued.	Reasonable
Charitable Funds (Deferred from 2023/24)	June / July 2024	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Value Based Healthcare	June / July 2024	Final report issued.	Reasonable
Discretionary Capital Funding Allocation (previously Capital Business Cases)	July / August 2024	Review in progress.	
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)	March / April 2025	Planning.	
Intelligence led organisation	July 2024	Final report issued.	Reasonable
Network and Disaster Recovery	September 2024	Final report issued.	Reasonable
Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)	June / July 2024	Final report issued.	Reasonable
Establishment Control and Recruitment	July / August 2024	Final report issued.	Reasonable
Integrated Assurance and Approval Plans (IAAP) • Llandudno Hospital Orthopaedic Hub	April to September 2024	Review in progress.	
Corporate Legislative Compliance: Fire Safety	May 2024	Final report issued.	Limited
Board Assurance Framework & Risk Management	January / February 2025	Review in progress.	
Standards of Business Conduct - Declarations of interest, gifts, and hospitality	February / March 2025	Planning.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	February 2025	Planning.	
Performance Management Framework & Reporting	January / February 2025	Brief agreed.	
Partnerships, Engagement and Communications	January / February 2025	Review in progress.	
Budgetary Control & Financial reporting	February / March 2025	Planning.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Standing Financial Instructions – Procurement	December 2024 / January 2025	Review in progress.	
Clinical Audit	December 2024 / January 2025	Draft report issued.	Limited
Effective Governance: Integrated Health Community – East	January / February 2025	Review in progress.	
Effective Governance: Cancer Services	December 2024 / January 2025	Review in progress.	
Consultant Job Planning	October / November 2024	Final report issued.	Unsatisfactory
Job evaluation	November / December 2024	Final report issued.	Not applicable
Waste Management	February / March 2025	Planning.	
Waiting List Initiative – IHC Centre	December 2024 / January 2025	Review in progress.	
People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)	June / July 2024	Deferred.	
Quality Governance: Concerns and Complaints	July / September 2024	Deferred.	
Corporate Legislative Compliance: Civil Contingencies Act 2004	June / July 2024	Deferred.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	October 2024 to March 2025	Deferred.	

Audit Assurance Ratings

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

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.

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

Table 6: Themes and definitions relating to Image 1

Ref.	Theme	Definition / Examples
1	Approvals	The internal control framework for securing approvals is ineffective. Appropriate approvals have not been sought/ obtained prior to key decisions.
2	Communication & Engagement	There is no clear communication strategy and/ or stakeholder identification arrangements. Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders. Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
3	Contractual	The form of contract is not appropriate and does not adequately protect the interests of the organisation. Contractual documentation has not been executed in a timely manner. The contract is not being applied as intended.
4	Cyber Security	There is no strategy for maintaining cyber security and/ or it is deficient. The strategy/ plans are not implemented as intended and are therefore ineffective.
5	Financial Management & Control	Financial controls and management information requirements have not been properly considered. The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.

Ref.	Theme	Definition / Examples
6	Governance	Inadequate / ineffective governance and oversight structures in place, which may include: • Absence of key roles and associated responsibilities to provide good governance. • Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees. General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.
7	Information & Data Quality / Accuracy	Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality. There is limited/ no guidance on the expected arrangements for data and information management. Insufficient records are maintained and/ or there are key gaps that would impact decision making. Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.
8	Lessons Learnt	There are inadequate or no systems and processes in place to capture lessons learnt. Lessons learnt are not regularly shared/ reviewed within the organisation. There is clear evidence that the organisation has not learnt from prior experiences.
9	Performance Monitoring	There are no/ limited systems in place to capture performance information. The systems are ineffective in capturing the required information to manage performance. Performance information is not monitored and/ or shared. Corrective action to address performance issues is not determined or is ineffective.
10	Physical Security	There is no strategy/ plan to maintain physical security. There is a lack of consideration of physical security needs (either current and/or future)
11	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set. Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.
12	Policies & Procedures	There are no policies or procedures in place, or they are inadequate to manage the risk. Policies or procedures are overdue for review or do not reflect current operational and/or best practice.
13	Reporting	Reporting and escalation requirements not clearly defined, including what gets reported where and when.

Ref.	Theme	Definition / Examples
		Defined reporting does not provide adequate information to support robust assurance, escalation and risk management. Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place.
14	Resourcing	Organisational planning and management approaches do not incorporate consideration of demand and capacity. Demand and capacity inadequately considered. Lack of proactive review of resource to deliver plans or business-as-usual activities.
15	Risk Management	Inadequate/ ineffective risk strategy, appetite and/or management arrangements. The approach to risk management and/ or arrangements applied are not operating as intended.
16	Strategy	An appropriate strategy has not been developed to outline the vision of the organisation. The strategy is not an effective tool in achieving organisational objectives.
17	Training & Development	There is no defined strategy for training and development. Training needs have not been identified. There is no plan in place to address identified training needs.

Internal Audit Plan 2025/26

Betsi Cadwaladr University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Betsi Cadwaladr University Health Board's (BCUHB) management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and 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

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations 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 Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

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 considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Three-Year Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Mandate and 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'). 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 both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies can add a provision for audit and assurance costs into the final business case for major capital bids.

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

2.3 Link to the Health Board's 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:

- A review of BCUHB's vision, values and forward priorities as outlined in the Three-Year Plan.
- An assessment of BCUHB's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees.
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the 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 considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of 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.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive 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 and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, 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 based on 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 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

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 BCUHB, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately based on a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by BCUHB, in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Nicola Jones
Deputy Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
1 Risk Management and Board Assurance Framework (Assurance) To review the effectiveness of Risk Management arrangements across the Health Board, and the development of the Board Assurance Framework	SO 1B BAF 24-01	Director of Corporate Governance	Q4
2 Follow up To review the evidence submitted by the Health Board to close audit recommendations resulting from, in the main, Limited Assurance reports and those defined as 'High Risk' in other reviews. This will be reported to the Audit Committee through Audit & Assurance progress reports. *A separate follow up review of Consultant Job Planning is included in the plan (see number 27).*	SO 1B BAF 24-01	Director of Corporate Governance	Q1
3 Corporate Legislative Compliance- Civil Contingencies Act 2004 (Assurance) To review the Health Board's compliance with the Act as a Category 1 responder. This will include a review of emergency and business continuity arrangements.	SO 1F BAF 24-01 *Deferred from 2024/25*	Executive Director of Public Health	Q1
4 Standards of Business Conduct (Assurance) To review compliance with the Standards of Business Conduct Policy.	SO 1A BAF 24-01	Director of Corporate Governance	Q3

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
5 Executive and Operational Leadership Team Governance (Assurance) To review the effectiveness of the leadership arrangements in place and how these are operating.	SO 1A BAF 24-01	Director of Corporate Governance	Q4
6 Public Health (Assurance) To review the approach taken to public care initiatives. We will consider how developments are assessed in terms of evidence and value and how they are tracked.	SO 4B BAF 24-06 CRR 23-08	Executive Director of Public Health	Q1
7 Value and Sustainability - improvements and savings delivery (Assurance) To review the value and sustainability approach to savings identification, reporting, monitoring and delivery.	SO 2I BAF 24-03 CRR 24-05	Executive Director of Finance	Q2
8 Budgetary Control and Financial Reporting (Assurance) To review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders.	SO 2I BAF 24-03 CRR 24-05	Executive Director of Finance	Q4
9 Budget Setting (All Wales review) (Assurance) To review how the Health Board allocates resources to meet its agreed budget. *Scope to be reviewed as part of planning.*	SO 2I BAF 24-03 CRR 24-05	Executive Director of Finance	TBC
10 Patient Experience (Assurance) To review the processes in place for capturing and utilising feedback to improve patient experience across the Health Board.	SO 4A BAF 24-06 CRR 24-02	Executive Director of Nursing and Midwifery	Q2

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
11 Learning (Assurance) To review the process for learning within the organisation. This will include learning from various sources, such as incidents, coroners reports and complaints.	SO 5E BAF 24-06 CRR 24-04	Executive Director of Nursing and Midwifery	Q1
12 Outpatient Transformation (Assurance) To review the work being undertaken to improve outpatient services. We will consider the progress and measurement of benefits, for example access to, and utilisation of clinics.	SO 4E BAF 24-07 CRR 24-11	Chief Operating Officer	Q2
13 Complaints (Assurance) To review compliance with the Integrated Concerns Policy published in 2024.	SO 5E BAF 24-06 CRR 24-02 *Deferred from 2024/25*	Executive Director of Nursing and Midwifery	Q1
14 Skills and Capabilities (Assurance) To review whether the required skills and capabilities for delivering and managing digital transformation across the organisation are identified and plans are in place to ensure they are brought into the organisation.	SO 2E BAF 24-02	Chief Digital and Information Officer	Q1
15 Delivering successful change and benefits realisation (Assurance) To review whether the Health Board has an appropriate framework and process in place to ensure business change is managed and that business cases are benefit focused and benefits are gained from investment in digital solutions.	SO 2E / 2G BAF 24-02	Chief Digital and Information Officer	Q2

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
16 Non Digital Data and Technology (DDaT) controlled IT (Assurance) To review whether there is an appropriate governance process for the management and use of IT system(s) controlled outside of DDaT. Consideration will be given to the accuracy of data held, security, and whether the system is used fully and consistent with the overall strategy and aims of the Health Board. Where Medical Devices are in use, to ensure appropriate management to ensure that patient data is secure, and that devices are updated and are subject to appropriate checks and segregation when connected to the Health Board network.	SO 2E BAF 24-02	Chief Digital and Information Officer	Q3
17 Community Services (Assurance) To review the governance arrangements in place for the management of community services provided by the Health Board. We will consider areas such as district nursing / school nursing and therapy services.	SO 4D BAF 24-07 CRR 24-19	Chief Operating Officer	Q1
18 Productivity and Efficiency (Assurance) To review the tools in place to measure productivity and efficiency across key services, to ensure resources (staff / theatres / clinics etc.) are being utilised effectively. *Areas for review to be discussed at planning stage.*	SO 4 BAF 24-06 CRR 23-08, CRR 24-13	Executive Director of Finance / Chief Operating Officer	Q2
19 Planned Care (Assurance) We will review the progress in delivering the planned care priorities (for 2024/25) set out in the Health Board Three	SO 4E BAF 24-07 CRR 24-11	Chief Operating Officer	Q3

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
Year Plan, and whether these have delivered the outcome of a reduction in overall waiting list sizes and lengths of waits.			
20 Urgent Emergency Care (Assurance) We will review the progress in delivering the urgent emergency care priorities (for 2024/25) set out in the Health Board Three Year Plan, and whether these have delivered the outcome improvements in Health Board delays within urgent and emergency settings.	SO 4G BAF 24-07 CRR 24-10	Chief Operating Officer	Q3
21 Primary Dental Care (Assurance) To review the arrangements in place for the management of primary dental care contracts and Health Board delivered services, to ensure timely and equal access to healthcare.	SO 4C BAF 24-06 CRR 24-19	Chief Operating Officer	Q2
22 Primary Medical Care (Assurance) To review the arrangements in place for the management of primary medical care contracts and direct Health Board delivered services, to ensure timely and equal access to healthcare.	SO 4C BAF 24-06 CRR 24-19	Chief Operating Officer	Q1
23 Workforce Planning (Assurance) To review the approach taken to workforce planning across the Health Board. We will consider workforce plans for areas across the Health Board and if these workforce plans in place across the Health Board consider how demand and capacity plans are linked to workforce plans.	SO 1G BAF 24-04 CRR 24-01	Director of Workforce and Organisational Development	Q2
24 Compassionate Leadership (Assurance)	SO 3A BAF 24-04	Director of Workforce and	Q4

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
To review the actions taken to create a compassionate leadership culture across the Health Board. We will consider the priorities and actions of the Organisational Development Plan, how these are progressing and the success measures in place.	CRR 24-16	Organisational Development	
25 Speaking Up Safely (Assurance) To review the arrangements in place for staff to raise concerns through the Speaking Up Safely process, and how these are reviewed, resolved and reported.	SO 3A BAF 24-04	Director of Workforce and Organisational Development	Q4
26 On-call arrangements (Assurance) To review the on-call arrangements in place across the Health Board and confirm these are operating effectively.	SO 1G BAF 24-04	Chief Operating Officer	Q2
27 Consultant Job Planning follow up To review the progress made against actions agreed in the 'Consultant Job Planning' audit undertaken in 2024.	SO 1G BAF 24-04	Executive Medical Director	Q2
28 NICE guidance compliance (Assurance) To review how the Health Board can demonstrate compliance with National Institute for Health and Care Excellence (NICE) guidance, i.e. through clinical pathways, clinical audits, patient surveys etc.	SO 4 BAF 24-06 CRR 24-02	Executive Medical Director	Q3
29 Agency utilisation (Assurance) To review the governance arrangements in place for the engagement and control of agency staff (both medical and non-medical) and to ensure that appropriate financial	SO 1G, 2I BAF 24-01	Director of Workforce and Organisational Development	Q3

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
controls are in operation to manage within the expected workforce establishment. We will consider the plans in place to eradicate the use of agency and how this is being implemented across the Health Board.			
30 Tertiary Care services (Assurance) To review the governance arrangements and performance of a specialist service, including improvement plans and actions. *Area to be reviewed will be agreed with Executive at planning stage.*	SO 2J BAF 24-07 CRR 24-12	Chief Operating Officer	Q3
31 Estate Management (Assurance) To review how the estate is managed to maintain a safe environment for staff and patients. We will consider oversight arrangements, risks and how these are mitigated.	SO 2 BAF 24-03 CRR 24-06	Director of Environment and Estates	Q3
32 Statutory Compliance: Asbestos Management (Assurance) To review compliance with the Control of Asbestos Regulations 2012 and associated Health Board Policy / Procedure.	SO 2 BAF 24-03 CRR 24-06	Director of Environment and Estates	Q4
33 Capital Systems (Assurance) To review whether appropriate controls are applied to the prioritisation and spend of the discretionary funding allocation for 2025/26 of £17m, together with the availability of Targeted Estates Funding (TEF) and year end monies provided by Welsh Government.	SO 2D BAF 24-03 CRR 24-06	Executive Director of Finance / Director of Environment and Estates	TBC

Planned output, Outline scope, Review reference	Strategic Objective (SO)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
34 Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance) To provide assurance on the systems and controls in place to deliver the works. *Note: The Infrastructure Programme was initially to be procured through the normal PBC/OBC/FBC process. However, for 2025/26 smaller amounts of funding have been released by Welsh Government to focus on key risk areas and priorities identified within the PBC. Accordingly, works are progressing outside of the OBC/FBC process and associated audit are unavailable. Future years provision will be considered as programme funding is secured.*	SO 2D BAF 24-03 CRR 24-06	Director of Environment and Estates	TBC
35 Integrated Regional Care Fund (IRCF) Projects (Assurance) To review delivery of primary care projects across North Wales, which received IRCF funding. *Note: The delivery of a number of these have been led by the UHB, whilst others have been delivered by the Local Authority, with the UHB specifying user requirements and entering into associated lease agreements. To date no audits have been undertaken on the delivery programme.*	SO 2D BAF 24-03 CRR 24-06	Director of Environment and Estates	TBC

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	⚑	To deliver plan
Audit opinion 2024/25 delivered by 31 May	⚑	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	⚑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	⚑	80%
Report turnaround management response to draft report [20 working days maximum]	⚑	80%
Report turnaround draft response to final reporting [10 working days]	⚑	80%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are 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 Mandate and 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 Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (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 is described in the Global 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 mandate and 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 Mandate and 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 Mandate and 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 Global 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 Director of Corporate Governance 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 Director of Corporate Governance 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. 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 Digital Health and Care Wales, NHS Wales Shared Services Partnership, and the Joint Commissioning Committee.

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 Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several 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 other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

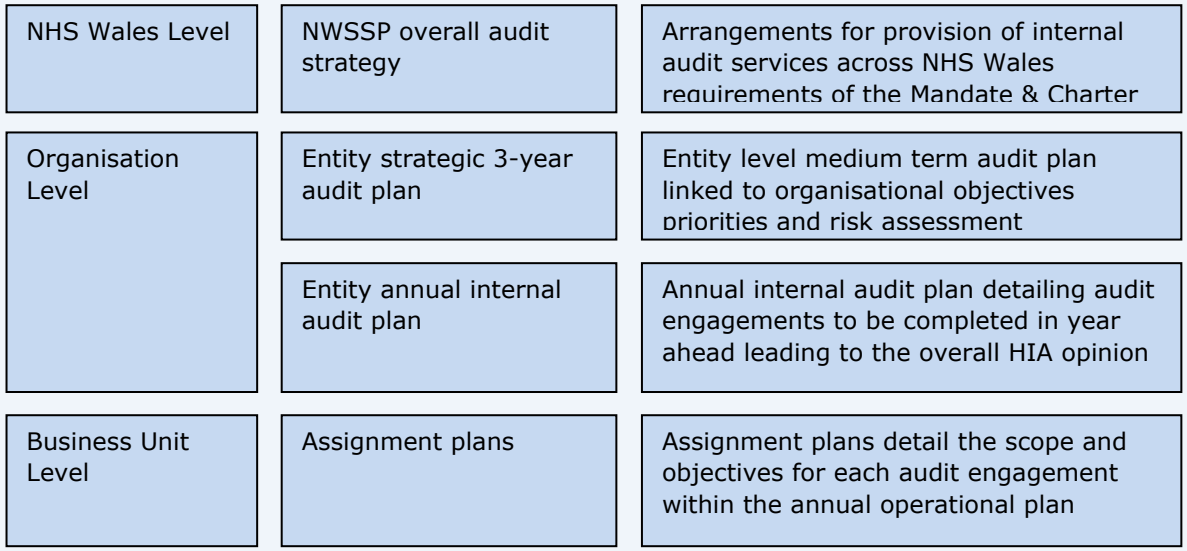
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Mandate and 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 Mandate and 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



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 Director of Corporate Governance.

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 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 to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- 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.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no

management response is forthcoming.

- Internal Audit issues a Final report to Executive Director 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, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance 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 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 is 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 Global 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 Global 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 Mandate and Charter

14.1 This Internal Audit Mandate and 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 2025

Disclaimer

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

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given regarding the advice and information contained.

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

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Job Evaluation

Internal Audit Report

2024/25

Betsi Cadwaladr University Local Health Board

Assurance rating not applied

Contents

Review Reference	BCU-2425-32
Fieldwork	November 2024 - December 2024
Executive Sign Off	21 January 2025
Audit Committee	March 2025
Executive Lead	Jason Brannan, Deputy Director of People & OD
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To assess how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the Health Board.

Overview

We have not assigned an assurance rating for this review as the evidence required to undertake part of the review has not been provided by the Health Board and we advised officers of this on 5 December 2024.

The matters requiring management attention include:

- Job evaluation procedures do not comply with Scheme of Reservation and Delegation (SoRD) Matter 10e, which states only the Service Director can approve review/re-band requests. Allowing a Head of Service and Line manager to submit requests is a breach and must be corrected immediately to comply with the SoRD.
- Due to non-provision of evidence, we were unable to provide assurance that controls are embedded to ensure there are no conflicts of interest in job matching panels and that consistency checking is undertaken in line with procedures and the job evaluation handbook.
- The implementation of approved re-banding/review outcomes are not, in the main, being actioned by operational management in a timely manner. Establishment control and/or lack of funding should not become a barrier to timely implementation of formal outcomes, as current procedures do not require outcomes to progress through another control process.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion or internal control and are highlighted for management information:

- We note an Independent Member is listed as both matcher and consistency checker and there is a risk that this could lead to a perceived conflict of interest as a Member of the Board.

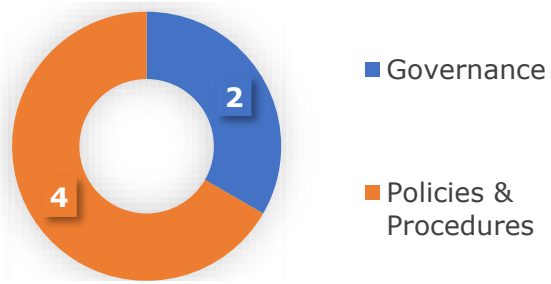
Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place, which set out the job evaluation process and promote fairness, consistency and equality for all members of staff.	1	**Reasonable**
2	Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	2, 3, 4, 5	**Not Completed**
3	Staff have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests.	-	**Substantial**
4	Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.	6	**Not Completed**

Management Actions

4	2
High Priority	Medium Priority

Themes



Risk Types

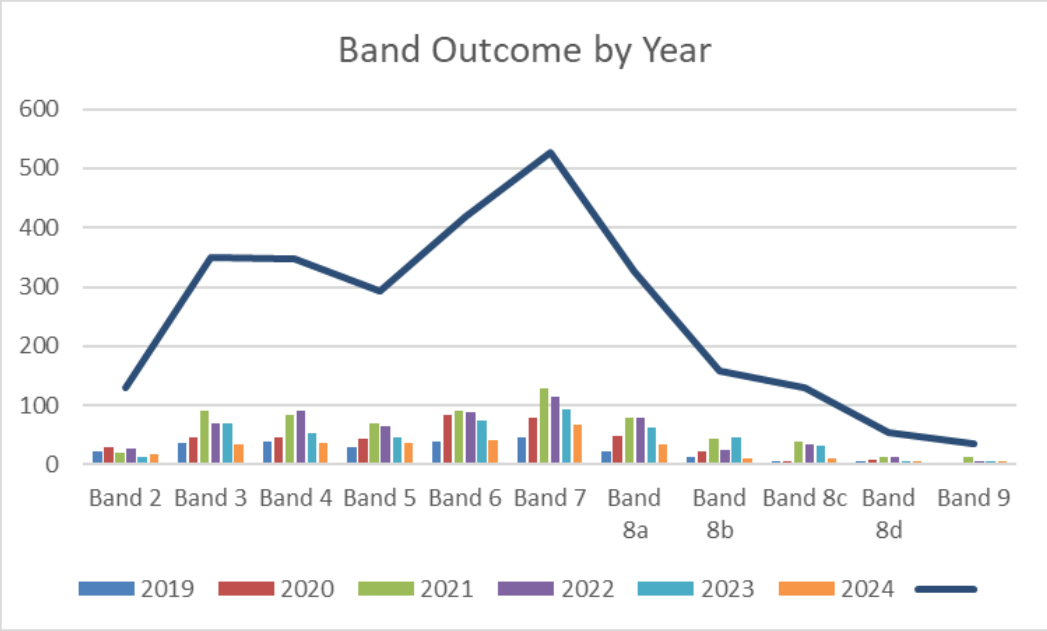
Legal & Regulatory Non-Compliance

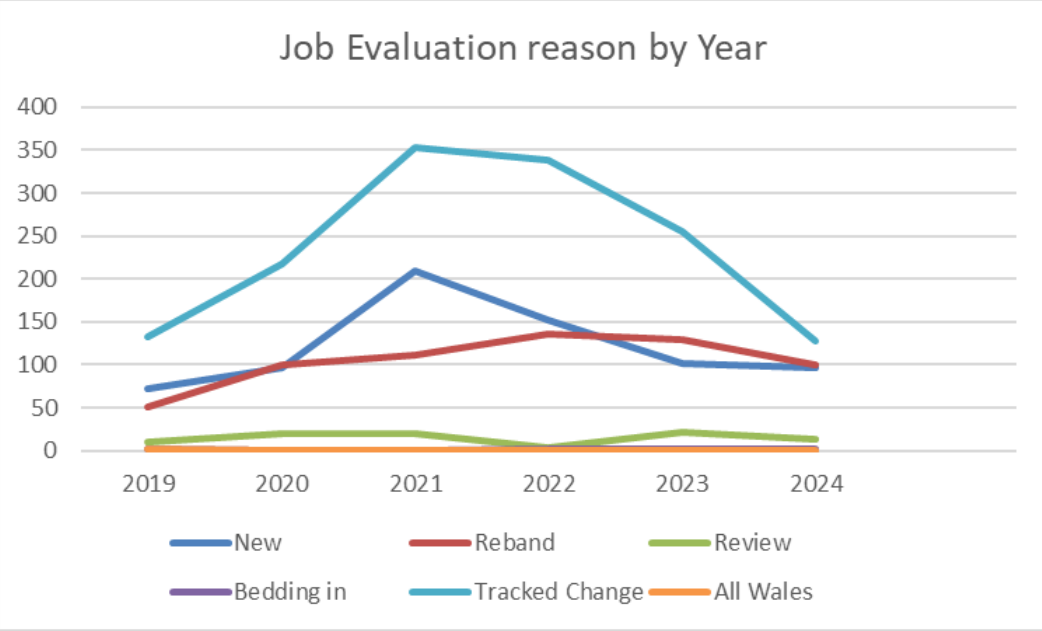
Financial Loss

Job Evaluation - At a Glance

Successful Band Outcome by Year for 2019 to 2024 – Data obtained from the Job Evaluation Team, People & OD (excludes bands yet to be assigned or submissions withdrawn)

Year	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
2019	23	36	39	29	40	47	22	13	7	6	2
2020	29	46	46	44	83	78	48	22	7	9	0
2021	21	92	84	70	91	129	80	43	40	14	14
2022	27	70	90	66	88	114	80	25	35	14	7
2023	14	70	52	47	74	93	62	45	31	5	7
2024	17	35	36	36	42	67	34	11	11	7	6
Total	131	349	347	292	418	528	326	159	131	55	36





Findings & Agreed Action Plan

Objective 1: The Health Board has appropriate policies and procedures in place, which set out the job evaluation process and promote fairness, consistency and equality for all members of staff.	**Reasonable**

Overview / Summary of Observations

There is a dedicated site on the Health Board intranet site, BetsiNet, that provides managers and colleagues with guidance and access to all Job Evaluation (JE) procedures and template documents, including access to all-Wales agreed job descriptions.

All procedures, focusing on JE are referenced between WP26a-e inclusive, were in date; reviewed in September 2023, live from November 2023 and scheduled for review by 28 September 2026.

The NHS Job Evaluation Handbook, Eighth Edition, January 2024 has been issued.

On 17 October 2024, the Health Board made a significant change to its procedure concerning *"…all posts band seven and above will need to be approved by the relevant head of service alongside the associate director of people services."* and for posts below band seven *"…the submitting manager/s will need to notify the relevant associate director of people services when a request is made for job evaluation."*

	Key Findings	Risk & Impact	Agreed Management Action
1	**Review of Health Board procedures on publication of new Handbook editions and changes to process** Current Health Board procedures are not reflective of the updated eighth edition handbook or the revised procedure instigated on 17 October 2024.	Health Board procedures do not reflect the current national guidance or process, impacting the first line of assurance.	**Agreed Action:** The new all Wales JE Policy was released in December 2024 which will supersede the current BCU WP26 JE procedures. As part of implementing the new policy, updated governance protocols will be incorporated in the associated operating procedures.
			Expected Evidence of Implementation: Updated Job Evaluation procedures that reflect changes when a new JE Handbook is issued and/or when changes to procedure are implemented.
		Medium Priority	**Officer:** Deputy Director of People & OD **Date:** 31 May 2025
	Theme: Policies & Procedures	Control Operation	

Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	**Not Completed**

Overview / Summary of Observations

We obtained the list of all Job Evaluation (JE) submissions recorded by the JE Team from 1 July 2019 to 13 November 2024 inclusive; Two thousand eight hundred and seventy-one (2,871) submissions were recorded for New (new post), Re-band (re-banding of existing post) or Review (review of the banding outcome where individual(s) is/are dissatisfied with the result of matching or evaluation).

Procedure WP26d - *Job Evaluation Procedures (For New, Vacant and Changed Posts)* section 1.2 focuses on re-banding with reference to line manager and job holder agreement, with sign-off by a Head of Service.

The Health Board's Scheme of Reservation and Delegation (SoRD) details Delegated Matter 10 e stating, *"All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure"* and delegated responsibility to the Service Director. Current procedures surrounding line manager and head of service approval for submission of re-banding are not compliant with the SoRD.

Based on our review of officers recorded as line manager and head of service, we found several instances where the line manager and head of service were the same, consequently there is an on-going risk from a lack of segregation of duties.

Relevant sign-off sheets were present for all re-band/review submissions; however, it is evident they are not approved by the Service Director, per the SoRD.

We sought to evidence that matching panels were not subject to conflicts of interest or that consistency checkers were not part of the matching panel to maintain independence in the process. We were unable to progress this as information was not shared with us by the Health Board; consequently, we have limited our scope and cannot complete testing in this area.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Scheme of Reservation and Delegation (SoRD) compliance** The Health Board's governing SoRD document includes Delegated Matter 10e, concerning requests for upgrading or regrading which is delegated to the Service Director. Job Evaluation procedures are not aligned with this requirement and permit submission of review/re-banding requests from a line manager and head of service, breaching the SoRD. There is no control to ensure appropriate segregation in line manager and head of service approval. We identified 285 (40%) of the 714 Re-band/Review submissions from 2019 to 18/11/24 were undertaken by the line manager who is also the head of service.	Non-compliance with the SoRD resulting in inappropriate authorisation and submission of review/re-banding requests.	**Agreed Action:** Under the new all Wales JE policy, procedures will be updated to incorporate an evaluation of banding reviews prior to them being submitted to the JE team. This new pre-evaluation sign-off will include the service director to meet the requirements on the SORD. **Expected Evidence of Implementation:** Updated Job Evaluation procedures that reflect the requirements of the SoRD, with final approval obtained from the relevant Service Director prior to submission for job matching, ensuring segregation of duties at all times.
	Theme: Governance	**High Priority** Control Operation	**Officer:** Deputy Director of People & OD **Date:** 31 May 2025

3	**Computer Aided Job Evaluation (CAJE) referenced Job Descriptions included in all vacancy adverts** We found two of the five new posts that were advertised included the correct job description with the CAJE reference and date noted. We broadened our review to current live posts advertised on TRAC (as of 28 November 2024) and found an instance where the job description had no CAJE reference - we could not verify if it was the correct band and description for the advertised role.	New appointments are made to incorrect job descriptions undermining the delivery of Health Board services.	**Agreed Action:** A communications notice will be issued to all recruiting managers that the CAJE reference is a mandatory field in the Establishment Control system. Subsequent sample audits of JDs will take place between the JE and EC team with compliance monitoring reported as part of the routine updates to Local Partnership Forum (LPF). **Expected Evidence of Implementation:** Revised Health Board procedure which mandates the verification of CAJE referenced job descriptions, relevant for the post, prior to placing the vacancy advert. Liaison with the Job Evaluation Team should be considered as a control in the process, without impacting the recruitment timelines.
		High Priority	**Officer:** Deputy Director of People & OD **Date:** 30 June 2025
	Theme: Policies & Procedures	Control Design	
4	**Conflicts of Interest in Job Matching Panels** We sought to evidence that matching panels were not subject to conflicts of interest or that consistency checkers were not part of the matching panel to ensure independence in the process. This information has not been provided for us to review.	Posts are subject to favourable banding in areas where the matchers either work or know individuals work, undermining integrity of the matching process.	**Agreed Action:** Due to current limited resource, there are instances in recent months whereby the same panel members have undertaken a JD review and also participated in consistency checking. A report of the number of instances where this has happened will be reported to LPF. To address the issue recurring, the JE team will aim to avoid holding any consistency checking panels without full independent members. Any consequent delays in the JE processing times will be reported to the JEPS steering going and Local Partnership Forum. If, in an exceptional circumstance, the same member has needed to sit on the matching and consistency panel, a declaration of interest will be recorded and reported to LPF. **Expected Evidence of Implementation:** Evidence the Deputy Director of People & OD has provided the Accountable Officer and Audit Committee with assurance that controls are in place to ensure no conflict of interest in matching panels (through review of panel attendance).

			Updated Job Evaluation procedures that reflect the requirement to ensure any conflicts of interest are declared at each panel and recorded accordingly.
		High Priority	**Officer:** Deputy Director of People & OD **Date:** 28 February 2025
	Theme: Governance	Control Operation	
5	**Panel outcomes are actioned in a timely manner** Following a review of recorded outcomes for our sample, we found that five of fifteen (33%) had not been actioned by management at the time of our review and were advised that the delays had been due to, in the main, the need to progress through establishment control and virements for the funding. We found the delays varied between two and seven months from the date of outcome and were still to be actioned. Establishment Control procedure has no reference to any requirement for a matched re-banding/review to go through a further set of controls, once it has been matched and consistency panel checked.	Panel outcomes are delayed impacting the working relationship with management leading to increases in Respect and Resolution incidents.	**Agreed Action:** As part of implementing the new all Wales policy, incorporating a pre-evaluation panel, the funding requirements will be identified prior to a banding review taking place. As such, there will be no requirement to withhold any alterations to banding/salary once the JE evaluation has taken place.
			Expected Evidence of Implementation: Revised establishment control procedure that reflects the requirement to allocate a new position number upon re-banding, to ensure delays to operational management processing staff change forms for post-holders is minimised.
		Medium Priority	**Officer:** Deputy Director of People & OD **Date:** 31 May 2025
	Theme: Policies & Procedures	Control Operation	

Objective 3: Staff have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests.	**Substantial**

Overview / Summary of Observations

There is detailed guidance available for staff and managers via the Job Evaluation pages on BetsiNet.

We were advised that online training is provided for colleagues to become job matchers or consistency checkers, with a hyperlink sent in advance of the training.

There is a list of trained matchers/consistency checkers, and we received a summary of both management and staff side colleagues who had been classified as regular/occasional/rare attendance. There are only seven management and seven staff side regular attendees (15%) from a total of ninety-one trained colleagues.

Objective 4: Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.	**Not completed**

Overview / Summary of Observations

We sought to evidence consistency checking was in line with Health Board procedure, however we have not been able to confirm this as the information needed to verify the officers undertaking the checks has not been provided to us.

	Key Findings	Risk & Impact	Agreed Management Action
6	**Consistency Checking compliance** Requirements for consistency checking are clear in both the Handbook and Health Board procedure, however compliance with expected control cannot be verified due to the evidence required to undertake the review not being provided.	The Health Board cannot verify the robustness of consistency checking and its compliance with the Job Evaluation Handbook or its own procedures.	**Agreed Action:** As per management response to item 4: Due to current limited resource, there are instances in recent months whereby the same panel members have undertaken a JD review and also participated in consistency checking. A report of the number of instances where this has happened will be reported to LPF. To address the issue recurring, the JE team will aim to avoid holding any consistency checking panels without full independent members. Any consequent delays in the JE processing times will be reported to the JEPS steering going and Local Partnership Forum. If, in an exceptional circumstance, the same member has needed to sit on the matching and consistency panel, a declaration of interest will be recorded and reported to LPF. **Expected Evidence of Implementation:** Evidence that the Deputy Director of people & OD has provided the Accountable Officer and Audit Committee with assurance that Consistency Checking is compliant with expected controls (i.e. report).
		High Priority	**Officer:** Deputy Director of People & OD **Date:** 28 February 2025
	Theme: Policies & Procedures	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

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Archwilio Cymru
Audit Wales

Final Accounts Memorandum – Betsi Cadwaladr University Hospital Board

Audit year: 2023-24

Date issued: September 2024

Document reference: 4487A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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 the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at 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

Final Accounts Memorandum Recommendations

Table 1 Financial Accounts - Summary of the issues and recommendations identified during the 2023-24 financial statements audit

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
1	**Notes 11.3 Right of Use Assets and Note 12 Intangible Non-Current Assets** The gross cost and depreciation for Right of Use Assets and Intangible Assets in the accounts did not agree to the value in CARS. However, the net position was correct. .	Review the Gross Cost and Depreciation values annually to ensure that there are no significant variances between CARS and the financial statements.	Agreed	The Gross Cost and Depreciation value difference was as a result of a manual adjustment outside of the ledger and CARS in 2022/23. We will look to correct the balances on the accounts for 2024/25 to ensure accuracy going forward.	March 2025
2	**Note 11.1 Property Plant and Equipment** CARS is currently unable to produce a report that details in year indexation of accumulated depreciation separately to the reversal of impairment impact. Therefore, the total in year movement is incorrectly shown within the Indexation heading in the	Liaise with CARS to arrive at a solution to report indexation and reversal of impairment separately for the preparation of Note 11.1.	To be discussed	Discussions have taken place with the developers of CARS to determine if that breakdown between the cost and depreciation section is possible. At this time it is still being investigated and may not be possible.	Ongoing

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	table in note 11.1 and the depreciation element of reversals of impairment is not shown.				
3	**Note 9.5 Exit Packages** The Health Board disclosed two exit packages in Note 9.5 for pay in lieu of notice (PILON) and pay in lieu of annual leave (PILOAL) for two members of the Board. On reviewing the accounts for similar payments made to other employees, we noted a further £265,000 of expenditure on PILON and £685,000 of PILOAL (excluding payments to agency and locum staff). The Health Board's approach has been to report redundancy payments, VERS Schemes and any pay in lieu of board members which is included within the Remuneration Report. Payments in lieu of any	Obtain further guidance from Welsh Government on the definition of exit packages in the Manual for Accounts and the basis for disclosing PILON and PILOAL for non-Board Members. Consider disclosing payments made other than to Board Members and information that the Finance team would require to ensure the transactions are	Agreed	The Welsh Government Manual for Accounts does not provide a definition of the term "exit packages" and the Health Board has sought advice from both Welsh Government and other NHS Wales organisations on transactions that are considered for inclusion in Note 9.5 "Reporting of other compensation schemes – exit packages". The Health Board currently reports all redundancy and VERS payments alongside extended disclosures for Directors reported in the Remuneration Report on the basis that an exit package is a negotiated settlement between an employer and employee typically involving compensation and additional benefits.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	other members of staff have not been included within Note 9.5. The NHS Manual for Accounts does not provide a further definition of exit packages; however, we are of the opinion that other cases should be considered when preparing this note as they would be of interest to the user of the accounts.	included going forward.		Whilst we await formal guidance the Health Board is collating and analysing data on all payments made to leavers during 2024-25, including the circumstances around each employee leaving the organisation.	
4	**Note 3.3 Expenditure on Hospital and Community Health Services** Testing of expenditure in Note 3.3 identified two separate issues with the recognition of prepaid expenditure. Issue 1 - Testing of a journal recharging photocopying rental charges from prepayments on the balance sheet to the relevant expenditure heading identified that £4,654 had failed to be journalled due to the code combinations on some lines being disabled.	Review the procedures in place for identifying and monitoring prepayments to ensure they are complete and accurately processed at year-end.	Agreed	Additional control checks have been established by the Head of Capital, Governance and Business Improvement to ensure that photocopier lease prepayments are fully accounted for. The specific issue for the NHS Supply Chain invoice was a residual issue from the Health Board's 2021-22 annual accounts when expenditure was incorrectly accounted for in the wrong accounting period.	August 2024

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	Issue 2 - Testing of a prepayment journal identified £4,937 from an NHS Supply Chain invoice for equipment maintenance had been missed from the prepayments balance at year end. The amount was fully recognised in 2022-23 in error and had not been identified through the current reconciliation process.				
5	**Note 9.2 Average number of employees** The NHS Manual for Accounts paragraph 1.256 requires the average number of staff employed to be calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The Health Board had calculated the average number of staff	Review the information requirements and calculation for Note 9.2 to meet the NHS Manual for Accounts paragraph 1.256 requirement for weekly rather than monthly whole-time equivalents.	Agreed	The average number of employees will be calculated on a weekly basis.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	employed on a monthly basis rather than on weekly basis.				
6	**Note 18 Trade and Other Payables** The Health Board's initial Annual Leave Accrual calculation for Medical Staff and Single Lead Employer (SLE) capped the leave carried forward at the permitted 5 days for all employees. However, this was then reduced to 3.5 days based on an estimation which could not be substantiated due to the limitations of accurate source data from the ESR system.	Take steps to improve the quality of the annual leave records held in the ESR system to enable the estimation for the 2024-25 accounts to be made on a more accurate basis.	Agreed	Workforce continue to encourage staff and managers to maintain accurate records on the ESR system, reminding them of their responsibilities. The Health Board will continue to report this particular accrual as part of the annual 'Judgements' paper which is presented and the methodology endorsed by the Audit Committee each year.	Ongoing
7	**Note 3.2 Expenditure on Healthcare from Other Providers** Testing of transactions identified £880,097 of expenditure with Digital Health Care Wales (a Special	Ensure the classification of NHS bodies is correctly mapped in the production of	Agreed	The Health Board has undertaken a review of expenditure coding with other NHS organisations to ensure that all items are being coded correctly at source.	August 2024

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	Health Authority) had been incorrectly classified under NHS Wales Trusts. The expenditure should have been reported in Note 3.3 Expenditure on Hospital and Community Services.	the financial statements and updated to reflect any change in status of NHS bodies as required.		This will in turn provide assurance that all NHS expenditure is mapped correctly in the 2024-25 annual accounts.	
8	**Note 3.3 Expenditure on Hospital and Community Health Services** Testing identified two transactions for External Consultancy Fees with VitaHub Ltd and Janet Ellis Consulting that were incorrectly coded as Agency expenditure and misclassified within Note 3.3.	Review supplier lists and default purchase order coding to ensure suppliers are correctly coded as External Consultancy or Agency suppliers.	Agreed	Default coding in the ledger is determined by the supplier and transaction type selected at the time that a requisition is created. The Health Board's Procurement Team has reminded Oracle users of the importance of selecting the correct category when raising requisitions and further additional reviews of both consultancy and agency spend are being undertaken by the Finance Department during 2024-25.	August 2024
9	**Note 2.2 Capital Resource Performance** As reported in our Report on the Financial Statements, gross capital	Ensure the preparation of Note 2.2 is updated to include the Capital Resource Allocation	Agreed	The RoU asset CRL will be included within Note 2.2.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	expenditure and Capital Resource allocation figures were incorrectly stated as they did not include the 'Right of Use Asset' additions for the year of £4,463,000.	and additions for Right of Use Assets as well as those owned by the Health Board.			
10	**Note 9.1 Employee Costs** As reported in our report on the financial statements, the disclosures relating to 'Agency staff' and 'Other' within the analysis of employee costs were incorrectly stated as some 'MEDACS' costs were incorrectly included. This also impacted on the disclosures in Note 9.2 'Average number of employees' with a number of 'Medical and Dental' included in error in Agency staff.	Revised reports that agree to the general ledger are used to complete the classification required for note 9.1 and 9.2 going forward for the 2024-25 financial statements.	Agreed	It has been agreed to produce the Medacs costs from the ledger to allow formal mapping from the ledger.	March 2025
11	**Note 9.6 Fair Pay Disclosures** As reported in our report on the financial statements, Note 9.6.1	Review all pay elements of Executive Director pay to ensure that	Agreed	The MfA will be followed to ensure accuracy in reporting Note 9.6.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	Remuneration Relationship and Note 9.6.2 Percentage Changes were amended for revised calculations for the Chief Executive and Highest Paid Director's total pay and benefits. The Chief Executive's pay had not included the additional contractual Retention Allowance. The Highest Paid Director was the Interim Director of Finance whose annualised salary exceeded that of the Chief Executive Officer.	disclosures in Note 9.6 are in line with the NHS Manual for Accounts requirements and the nature of the pay awarded.			
12	**Note 11.1 Property, Plant and Equipment** As reported in our report on the financial statements, testing identified £3,472,000 of additions in year were misclassified as additions to 'plant and machinery'	A manual process is currently required to separate additions and reclassifications with Assets Under Construction records maintained outside of CARS. Explore the potential for Asset	Agreed	An additional quality check will be incorporated into the process, to review classifications.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	when they related to ‘assets under construction’. As the assets came into use during the year an amendment was also required to move the amount into plant and machinery through the ‘reclassification’ line. We also identified £39,000 of reclassifications that were misclassified as reclassifications to ‘plant and machinery’ when they should have been treated as reclassifications to Information Technology.	Under Construction records to be transferred and maintained in CARS. Review in year reclassifications and ensure they are accurately recorded in the ledger and note.			
13	**Note 11.3 Right of Use Assets** Welsh Government inserted an additional line to Note 11.3 ‘Right of Use Assets continued – Quantitative Disclosures’, within the ‘Contractual undiscounted cash flows relating to lease liabilities’ table titled ‘Less	Liaise with Welsh Government on any late changes to the financial statements format and obtain confirmation on any changes made to the draft	Agreed	This amendment to the accounts proforma was made by Welsh Government when the unaudited accounts submission had been returned for other minor amendments be made and was not communicated to health bodies. The Health Board will maintain a list of any amendments made to the draft accounts	April 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	finance charges allocated to future periods'. Amendments were made to 2023-24 and 2022-23 balances for 'Less Finance charges allocated to future periods' and 'Total undiscounted cashflows'.	submission and validation checks.		proforma in 2024-25 and will confirm the completeness of this list with Welsh Government.	
14	**Note 18 Trade and Other Payables** Testing identified £10,295,000 that was misclassified as 'Non-NHS accruals' when it should have been included as 'Non-NHS payables - Revenue'. This was the result of a change in the definition of accruals and payables within the 2023-24 NHS Manual for Accounts.	Ensure all changes contained in the NHS Manual for Accounts are applied when preparing the draft financial statements.	Agreed	All changes in the Welsh Government Manual for Accounts are reviewed and applied by the Head of Financial Control and Head of Capital, Governance and Business Improvement each year. During 2023-24, in accordance with the amended requirements of the Manual for Accounts, the Health Board had reported all system generated liabilities as payables rather than accruals. The isolated issue resulted from the value of an accrual estimate crystallising before the annual accounts submission date and	April 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
				therefore becoming a payable but not being amended within the general ledger.	
15	**Note 21.1 Contingent Liabilities** During our audit we were made aware that the Health Board had received invoices in relation to historical transactions for the provision of care within the local community. Our review of the disclosure requirements for the issue determined that additional disclosure within 'Contingent liabilities' was required, and an additional narrative disclosure was included.	Monitor the situation for changes to the likelihood of the liability arising during 2024-25. The disclosure should be amended to reflect changes to the likely outcome or removed if resolved for 2024-25.	Agreed	This issue was first brought to the attention of Audit Wales by the Health Board, and clarification of the required treatment was welcomed. The disclosure will be reviewed again at year end and amendments made as necessary.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
16	**Note 30 Related Party Transactions** Several related party disclosures were removed from the disclosure note as there was no evidence of significant influence or control over the Health Board or the related party in accordance with the requirements of International Accounting Standard 24 (IAS24).	From the full list of related party disclosures, determine those that meet the definition of related party in accordance with IAS24 in preparing Note 30. Document the judgment made on those included and excluded from the Note.	Agreed	A working paper which documented the judgement as to which Declarations of Interest should be included in the Related Party Transactions note was provided to Audit Wales as part of the 2023-24 annual accounts working papers and will be provided again in 2024-25. The Health Board has also developed a criteria list based on disclosures in 2023-24 which will assist with ensuring that only Declarations of Interest that meet the criteria in IAS24 are included in the Related Party Transactions note.	April 2025
17	**Amendments relating to the Welsh Risk Pool (WRP) return** Due to an error in the supporting working paper, contingent liability defence costs were overstated by £19,000 in Note 21 Contingent Liabilities and the WRP Return.	Ensure the WRP return is completed accurately and is agreed to balances in the financial statements.	Agreed	The Health Board will include additional checks in the 2024-25 annual accounts preparation to ensure that the Welsh Risk Pool returns agree to annual accounts working papers and balances.	April 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	The narrative in Note 21.2 Remote Contingent Liabilities for amounts recoverable from WRP was understated by £61,000 as it did not include the General Medical Practice Indemnity balance. The WRP was correctly stated. The split of current and non-current receivables in the WRP Return were misstated by £3,502,000 as cash paid relating to current claims was misclassified. The balances in Note 15 Trade Receivables were correctly stated.				
18	**Note 34.2 Pooled Budget Memorandum** Note 34.2 2022-23 comparative figures, for the Cumulative Net surplus/deficit for the Pooled Budget for Denbighshire Community Equipment Service Memorandum had been updated to the final 2022-23 Statement of Accounts. Narrative	As local government accounts audits conclude after the Health sector, ensure prior year figures in the memorandum item are reviewed for any restatements to be noted.	Agreed	The Health Board will request final audited copies of pooled budget memorandum statements from each local authority following the statutory deadline for certification of their 2023-24 annual accounts on 30th November 2024.	December 2024

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	was added to show the figures were restated.				

Table 2 Information Technology - Summary of the issues and recommendations identified during the 2023-24 financial statements audit

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
19	The CARS server hardware and operating system is Windows 2012 R2 Server which is no longer supported. Operating systems that are unsupported by manufacturer are a cyber security risk as known security vulnerabilities and weaknesses are present which could be exploited by a malicious individual.	As the server hardware and operating system are now unsupported it is recommended that it is migrated to newer, supported versions or explore alternative options maintain the security and compliance of IT applications.	Agreed	Evidence has been provided to audit as CARS was moved to a new server	July 2024
20	The estate orders feeder system GRAMMS server hardware and operating system is Microsoft Windows Server 2008R2 which is no longer supported. Operating systems that are unsupported by manufacturer are a cyber security risk as known security vulnerabilities and weaknesses are present which could be exploited by a malicious individual.	As the server hardware and operating system are now unsupported it is recommended that it is migrated to newer, supported versions or explore alternative options maintain the security and compliance of IT applications.	Agreed	The Estates Teams intends to further consider the migration of the GRAMMS to Oracle System in due course.	Ongoing/TBC

Table 3 Governance - Summary of the issues and recommendations identified during the 2023-24 financial statements audit

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
21	**Remuneration Committee** While auditing entries within the Remuneration Report, we identified several governance weaknesses around the administration of the Remuneration Committee. These included: • Committee meeting missing from the iBabs system. • Reference to incorrect meeting minutes when confirming them as reviewed for accuracy. • A lack of record for actions and approvals within the minutes. • Incorrect meeting dates on reports submitted. • The incorrect pay band of ESP14 was reported for the appointment of the Interim Executive Director of Finance and should have been ESP15. • Insufficient audit trail of decisions taken not to delegate the responsibility of the Executive Director of Workforce Organisational Development and for the Chief Executive to retain the responsibility.	Governance around the Remuneration Committee is strengthened to ensure a full and factual record of decisions is maintained. The record is corrected regarding the pay band to which the Interim Executive Director of Finance was appointed to at the next available Remuneration Committee meeting.	Agreed Agreed	Review of the papers and supporting papers will be undertaken (Director of Corporate Governance) The Committee will correct the record **(Completed)**	November 2024 July 2024

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
22	**Formal appointment of Executives** A retrospective Letter of Appointment was issued to the Acting Director of Public Health on 12 June 2024 and provided as supporting evidence of appointment prior to 31 March 2024 during the audit. The contract for the Chief Executive Officer remained unsigned after negotiations had concluded on the remuneration for the post. A signed copy dated 13 June 2024 was provided as supporting evidence of the appointment prior to 31 March 2024 during the audit.	Employment contract procedures should be reviewed to ensure that formal appointment documentation is completed on a timely basis and at the time of appointment.	Agreed	Audit tracking system to be developed to include all contractual documents for all appointments (Director of Corporate Governance)	November 2024
23	**Contracts** There was a transposition error in the retention allowance of £13,328 stated in the contract of employment for the Chief Executive Officer. The correct allowance presented to the Remuneration Committee and paid was £13,238.	Action is required to amend the contract of employment for the correct retention allowance of £13,238.	Agreed	Corrected.	July 2024

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
24	**Annual Governance Statement** In reviewing the Annual Report and Annual Governance Statement, several issues were identified that required amendment, including: • The Performance report and Directors Report did not meet all of the NHS Manual for Accounts requirements and further detail was required. • A number of differences were noted between values used in the Performance Report and the Financial Statements. • Discrepancies in the details of the Board and committee meetings held during the year.	The Annual Accounts and Annual Governance Statement should be quality reviewed and agreed by Finance prior to submission to ensure it is factually correct, agrees to the financial statements and addresses all Manual for Accounts requirements.	Agreed	Clear timetable to be developed setting out the key responsibilities to ensure the quality of the documents submitted **(Director of Corporate Governance and Director of Finance)** Quality Assurance processes will be put in place to avoid errors in the AGS **(Director of Corporate Governance)**	January 2025

Table 4 Remuneration Report - Summary of the issues and recommendations identified during the 2023-24 financial statements audit

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
25	**Narrative amendments and disclosures** Amendments and additional disclosures were required to ensure the Report was accurately presented, including: • Additional disclosures were required to state that the Staff Composition and Sickness Absence tables excluded bank and SLE assignments in the calculation. • Additional narrative required under 'Exit Packages and Severance Payments' and amendments to the appendix heading on the final page. • Narrative corrected for job titles in the committee member's table. • An additional footnote was required to disclose clearly a secondment and end of fixed term contract in the table. • Spelling mistakes were including in the word renumeration instead of remuneration. • The Single Total figure of remuneration and Pension Benefit 2023-24 tables did not have headings.	The Remuneration Report should be quality reviewed before submission for omissions, errors and formatting to be corrected.	Agreed	The finance team will work closely with the Board Secretary and the Corporate Governance Team to ensure information from the Remuneration Committee will be shared to ensure accuracy within the Remuneration Report.	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
26	**Amendments to disclosures in the 'Single Total Figure of Remuneration' table.** • The incorrect effective date of appointment had been applied to the disclosure of the Acting Director of Public Health, resulting in their remuneration being overstated in the table. • The Chair of the Board was also the Interim Chair before he was appointed into the substantive role on 1 March 2024. The disclosures within the table for his role was amended to disclose both roles separately. • The Interim Chief Executive and the Interim Executive Director of Operations were on secondment from other Health bodies for part of the year. The table was amended to disclose the total remuneration of the seconded Executive Directors in line with Chapter 3 of the NHS Manual for Accounts.	Procedures for preparing the Remuneration Report should be reviewed to ensure the following information is correctly recorded during the year: • the effective date of appointments, • changes in interim and substantive appointments; and • details of secondments from other Health bodies.	Agreed	The MfA will be used as a baseline to ensure that disclosures within the Remuneration Report is accurate.	March 2025
27	**Full Year Equivalent (FYE) salary calculations and banding** Amendments were required to the salary calculations and banding disclosed for the following Board members:	Procedures for preparing the Remuneration Report should be reviewed to ensure salary calculations and banding are accurate.	Agreed	The process for producing the calculation for the Remuneration Report will be reviewed to	March 2025

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	• The previous Interim Executive Director of Finance was amended from band £245,000-£250,000 to band £270,000–£275,000. The amendment also impacted the highest paid Director under the Remuneration Relationship section of the report. • The previous Executive Director of Workforce and Organisational Development was amended from £185,000-£190,000 to £155,000-£160,000. • The Vice Chair was amended from £35,000 - £40,000 to £40,000 - £45,000. • Comparative disclosures were not included for the previous Interim Board Secretary.			ensure additional quality checks are implemented to improve the Remuneration Report.	
28	**Pension Benefits Table** The following errors were identified in the in the Health Board's pension calculation working paper: • A transposition error resulted in the Real Increase in Accrued Pension being misstated. • A formula error in the number of days calculated resulted in the pension banding for Executive Director of Nursing and Midwifery's pension being misstated. • Cash Equivalent Transfer Values (CETVs) were incorrectly calculated by not including the 2015	Procedures for preparing the Remuneration Report should be reviewed to pension benefit calculations are accurate.	Agreed	The process for producing the calculation for the Remuneration Report will be reviewed to ensure additional quality checks are implemented	Agreed

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	Scheme. The 2023-24 CETV values were amended for five Directors and comparators within the disclosures. • Pension benefits for Executive Directors who joined the Health Board during the year (both interim and substantive) were overstated, due to the NHS Manual for Accounts specifying a particular calculation. The pension disclosures were removed for four Executive Health Board officers.			to improve the Remuneration Report.	
29	**Amendments to comply with the NHS Manual for Accounts requirements** The number of off payroll engagements of board members and / or senior officials with significant financial responsibility between 1 April 2023 and 31 March 2024 disclosed as 2 in error. The actual number was 1. The figures within the table of 'Average Number of Full Time Equivalents' in the Staff Report were amended to bring them in line with the Permanent Staff figures disclosed in Note 9.2 in the accounts and with the NHS Manual of Accounts requirements.	Procedures for preparing the Remuneration Report should be reviewed to ensure compliance with the requirements in the NHS Manual for Accounts.	Agreed	The process for producing the calculation for the Remuneration Report will be reviewed to ensure additional quality checks are implemented to improve the	Agreed

Ref	Issue	Recommendation	Agreed	Audited body responsibility and actions	Completion date
	An analysis on the total number of staff in receipt of Remuneration Packages in excess of £100,000 was removed as the disclosure is not required by the NHS Manual for Accounts. Taxable reimbursements paid to Independent Members of the Health Board home to the Health Board's headquarters travel in the year were not included in the draft Remuneration Report as required by the NHS Manual for Accounts. These were added to the renamed 'Taxable Benefits' column as well as in an additional footnote.			Remuneration Report.	

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Archwilio Cymru
Audit Wales

Annual Audit Report 2024 – Betsi Cadwaladr University Health Board

Audit year: 2023-24

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2024 audit work at Betsi Cadwaladr University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.

6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI[1] auditing standards.

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2024 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Executive Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on 4 March 2025. The Board will receive the report at a later Board meeting. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I issued an unqualified true and fair opinion on the Health Board's 2023-24 accounts.

13 I issued a qualified regularity opinion for 2023-24 as the Health Board:

- Did not break-even against its Revenue Resource Limit over the three years 2021-22 to 2023-24, failing its first financial duty.
- Incurred irregular expenditure for payments made to an interim executive member of the Board.

14 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the regularity qualifications noted above and that the Health Board did not achieve its second financial duty to prepare a three-year integrated plan.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of performance audit work has led me to draw the following conclusions:

- The Health Board and its regional partners understand and show a commitment to improving patient flow out of hospital. However, the number of medically fit patients occupying hospital beds remains very high. Regional partners must continue to work both individually and collaboratively to set and implement clear guidance, mitigate the challenges posed by reduced capacity and increased complexity of care, and ensure the impact of activities is continually monitored, challenged, and maximised.

- The Health Board has made limited progress in addressing our previous recommendations relating to discharge planning. While the introduction of Discharge to Recover then Assess improved the Health Board's approach to discharge planning, challenges remain relating to training, compliance with guidance, embedding initiatives and reporting discharge planning performance at Board and committee level.
- Whilst the Health Board exceeded its savings target and almost met its control deficit target for 2023-24, its track record of delivering recurrent savings has been variable. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on rolling out and embedding its new cost savings arrangements across the organisation.
- Since last year's structured assessment and our follow up work on board effectiveness, there have been positive developments in some of the Health Board's key corporate governance arrangements and progress in recruiting to some business-critical senior roles. However, there remains much to do especially in respect of establishing a stable, cohesive and high performing Executive Team, developing a longer-term strategy and supporting Clinical Services Plan, and ensuring the Health Board's organisational structure and operating model is fit for purpose.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4**, **Appendix 3**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

20 I issued an unqualified true and fair opinion on the Health Board's 2023-24 accounts.

21 We reported in the prior year that the 2022-23 financial statements were not presented to audit to the standard expected. For 2023-24 there was a significant improvement in the quality of the draft financial statement presented for audit. This is illustrated by the relatively small number of misstatements that were identified and amended and the fact that there are no unadjusted misstatements arising from the audit.

22 The draft financial statements were also supported by comprehensive and timely working papers. The finance team was also able to provide us with the full mapping used to prepare the financial statements from the general ledger. This enabled the audit team to utilise Analytics Assisted Audit software and tools when undertaking the audit, enhancing the transparency of the content of financial statements for both the finance and audit team.

23 Whilst I identified improvement with the quality of the draft 2023-24 financial statements, the draft Remuneration Report required significant amendment to ensure the information reported was factually accurate and it fully complied with the requirements of the NHS Manual for Accounts issued by Welsh Government.

24 My team's review of the Remuneration Report identified several areas where governance arrangements need to be improved by the Health Board. These include the arrangements for appointing officers at a senior level and improved documentation of decisions taken by the Remuneration Committee.

25 I identified that an officer member of the Board was paid at a pay point that significantly exceeded the maximum pay point for the role as set out by Welsh Government. My team established that the Standing Financial Instruction (SFI) requirements were not followed as approval was not obtained from the Board or Welsh Ministers as required.

26 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the

accounts. My Financial Audit Engagement Lead reported these issues on 10 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were no non-trivial uncorrected misstatements in the accounts.
Corrected misstatements	A small number of amendments were made to the Financial Statements. The amendments did not impact on the prime statements within the financial statements, only on the disclosures within a small number of notes to the accounts, in particular the disclosure of the 'Fair Pay Disclosures' and 'Remuneration Relationship' within note 9.6. The Remuneration Report required significant revisions to ensure the information was factually accurate and in accordance with the NHS Manual for Accounts. The 'Single Total Figure of Remuneration' and 'Pension Benefits' tables required several amendments including: • Correction to the remuneration figures of three executives and one independent member. • Correction to the disclosed roles of an independent member. • The inclusion of two executives on inward secondment that were omitted. • The correction to pension benefit figures for four executives. • The inclusion of taxable benefit amounts for seven independent members that were omitted. • The inclusion of comparative disclosures for an executive previously omitted. • The correction to Real increase in Accrued Pension and Lump Sum figures for one executive. • The correction to Cash Equivalent Transfer Value figures for five executives.

Issue	Auditors' comments
	There were also several minor amendments made throughout the report
Other significant issues	The Health Board significantly improved the quality of the draft financial statements presented for audit, however we noted that significant improvement was needed to the quality of the Remuneration Report presented for Audit Wales. For the second consecutive year I raised concerns with governance arrangements that contributed to irregular payments being made by the Health Board.

27 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2024 and the return was prepared in accordance with the Treasury's instructions.

28 My separate audit of the charitable funds accounts is complete, with an unqualified audit opinion issued. My team identified issues relating to the misclassification of donations. This related to a significant proportion of donations being incorrectly accounted for, which resulted in material amendments needed to ensure correct classification. The charitable funds accounts were subsequently amended and, as a result, this has not impacted our audit opinion. I recommended the Charity reports with more clarity to the Charitable funds Committee when funding for projects falls below that approved and previously recognised. We also reported that the working papers provided for audit were of a better quality from prior year but need to continue to be developed to further improve the efficiency of the audit process.

Regularity of financial transactions

29 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

30 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

31 The Health Board did not achieve financial balance for the three-year period ending 31 March 2024 which I deem to be outside its powers to spend, so I issued

a qualified opinion on the regularity of the financial transactions within the Health Board's 2023-24 accounts.

32 The Health Board also breached its resource limit by spending £23.669 million over the amount that it was authorised to spend in the three-year period 2021-2022 to 2023-2024.

33 The Health Board made payments to an Interim Executive Director of Finance, appointed in January 2023, at a rate in excess of the salary band as set by Welsh Government. The Health Board's SFIs paragraph 14.1.2 requires the appointment of officer members of the Board be reserved for full Board approval. SFI 14.1.4 also requires Welsh Ministers' approval where an officer member of the Board is paid more than the Welsh Government's approved salary band. We established that the SFI requirements were not followed as approval was not obtained from the Board or Welsh Ministers. I deem this expenditure to be outside its powers to spend, so I issued a qualified opinion on the regularity of this transaction recognised within the Health Board's 2023-24 accounts.

34 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the issues set out above, I issued a substantive report setting out the factual details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

35 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the effectiveness of the Health Board's arrangements, in partnership with social services, to support timely patient flow out of hospital across the North Wales Region;
- assessing the extent to which the Health Board has implemented my 2017 recommendations on discharge planning;
- reviewing the effectiveness of the Health Board's cost savings arrangements;
- undertaking a structured assessment of Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

36 My conclusions based on this work are set out on the following pages.

Urgent and emergency care

37 My work examined different aspects of the urgent and emergency care system focused on patient flow out of hospital and progress against my previous discharge planning recommendations. My work was reported in September 2024.

Patient flow out of hospital

38 My regional review examined whether the Health Board and its social services partners have effective arrangements to ensure the timely discharge of patients out of hospital. It focussed on the scale of the challenge, and the factors impacting on effective and timely flow out of hospital. My work also considered the action being taken by the Health Board and its statutory partners, including through the Regional Partnership Board, and what more can be done to reduce some of the challenges currently being experienced by the health and social care system.

39 My work found that **The Health Board and its regional partners understand and show a commitment to improving patient flow out of hospital. However, the number of medically fit patients occupying hospital beds remains very high. Regional partners must continue to work both individually and collaboratively to set and implement clear guidance, mitigate the challenges posed by reduced capacity and increased complexity of care, and ensure the impact of activities is continually monitored, challenged, and maximised.**

40 The extent of discharge delays in North Wales has grown significantly in recent years and between April 2023 and February 2024, each month there were on average 334 medically fit patients whose discharge was delayed, with completion of assessments the main cause for delay. For the year up to and including February 2024, the total number of bed days that had been lost to delayed discharges was 71,871 with a full-year cost equivalent of £39.202 million. The consequent impact on patient flow within hospitals and the urgent and emergency care system is significant, with waiting times in emergency departments and ambulance handovers falling well short of national targets. In February 2024 alone, there were over 8,000 lost ambulance hours because of handover delays, and the average wait within the Health Board's emergency departments was around 8.5 hours.

41 Several factors are contributing to delayed discharges. Many patients have complex needs that are not easily met by the services that are available. There are also workforce challenges within the social care sector, particularly in the areas of Conwy, Denbighshire, and Gwynedd. Our work identified numerous weaknesses in the practice and documentation of discharge planning and a need to implement the Discharge to Recover and Assess (D2RA) model as intended.

42 Partners are working together, both strategically and operationally, to improve patient flow, however, pressures on the system are creating an unhelpful blame culture. Financial resources are being applied to improve discharge planning, although financial constraints in partner bodies are leading to the continual roll forward of schemes and ultimately leaves little space for new ideas. Whilst there is

regular monitoring of the position within individual organisations, partners lack arrangements to oversee patient flow across the whole health and care system.

43 Partners also need to maximise the use of the Regional Integration Fund (RIF), improve oversight and impact of the initiatives that are being undertaken to support timely and effective discharge, and ensure learning from events is embedded into routine practice.

Discharge planning: progress update

44 In undertaking my regional review of arrangements to support patient flow, I have also taken the opportunity to consider progress made by the Health Board in addressing my previous 2017 recommendations relating to discharge planning.

45 My work found that **the Health Board has made limited progress in addressing our previous recommendations. While the introduction of Discharge to Recover then Assess altered the Health Board's approach to discharge planning, challenges remain relating to training, compliance with guidance, embedding initiatives and reporting discharge planning performance at Board and committee level.**

46 My follow up work found that none of the 2017 recommendations were fully addressed. In particular, I found:

- no evidence that the Health Board was providing training on discharge planning or pathways to new or existing relevant staff at the time of fieldwork, though some training activity has since started.
- limited evidence the Health Board had introduced a routine cycle of audit to determine the extent of compliance with its discharge approach.
- the Health Board is now adopting the nationally mandated Discharge to Recover then Assess pathways, although there remain difficulties in consistent application due to capacity issues.
- that Health Board no longer uses the 'golden hour programme' to encourage discharges before 11am, nor does it report the time of discharge although it states it is working to encourage morning discharges.
- that there remains a lack of understanding of services available in the community, which are needed to help support effective and timely discharge planning.
- that although there is service monitoring at an operational level, performance reporting to the board and its committees on discharge planning and patient flow out of hospital had not been strengthened, despite the significant and ongoing pressure on the Health Board caused by poor patient flow.

Review of cost savings arrangements

47 My review examined whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It considered the impact these arrangements had on the Health Board's 2023-24 year-end position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

48 My work found that **whilst the Health Board exceeded its savings target and almost met its control deficit target for 2023-24, it has a varied track record of delivering recurrent savings. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on rolling out and embedding its new cost savings arrangements across the organisation.**

49 The Health Board has a good understanding of its cost drivers. Reports highlight areas of high cost such as pay and non-pay costs (including nursing and medical agency costs), continuing health care, and medicines management. These high-cost areas continue to be key contributors to the challenging financial position and significant underlying deficit. However, opportunities remain to strengthen this approach to meet its financial challenges in both the short- and longer-term. The Health Board is still in the process of developing a clearer longer term Strategic Plan and Clinical Services Strategy. These are of fundamental in driving the service transformation that is needed to establish clinically and financially sustainable service models.

50 Whilst the Health Board's delivery of recurrent savings improved in 2023-24, savings performance was variable across its Integrated Health Communities and Directorates. The Health Board also has a variable track record of delivering recurrent savings. The Health Board's new 2024-25 Value and Sustainability Board workstreams were being finalised at the time of our review. The proposed governance structure for the individual workstreams should result in better engagement across the Health Board and increase the success of delivering savings schemes benefits. However, it will need to continue to strengthen financial competencies across the organisation if it is to achieve its challenging 2024-25 savings target.

51 The Health Board's arrangements for scrutinising, monitoring, tracking, and reporting on cost savings are improving. The Board has a clear understanding of the Health Board's financial challenges through its regular finance and savings reports. However, they have not resulted in improved financial performance across the organisation. It needs to strengthen how it holds Integrated Health Communities and Directorates to account for savings under-delivery and share best practice and the lessons learnt from ineffective savings schemes.

Structured assessment

52 My 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances,

workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

53 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

54 At the time of my structured assessment work, the Health Board was subject to Level 5 under the Welsh Government's escalation and intervention arrangements.

Board transparency, effectiveness, and cohesion

55 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business
- Arrangements to support the conduct of Board business
- Board and committee structure, business, meetings, and flows of assurance
- Board commitment to hearing from staff, users, other stakeholders
- Board skills, experiences, cohesiveness, and commitment to improvement

56 My work found that **there is now a full cadre of substantive independent members on the Board and that board and committee meetings are conducted appropriately and transparently. However, ongoing instability within the Executive Team, gaps in wider senior leadership structures, and ongoing challenges with the operating model are compromising the Health Board's ability to tackle the significant challenges it faces.**

57 There is now a full cadre of substantive independent members on the Board there remains instability within the Executive Team and gaps in some of the wider senior leadership structures. While the Health Board made several senior management appointments, key roles remain vacant, requiring colleagues to temporarily adopt additional responsibilities. In addition, the Health Board's operating model introduced in 2022 is not fit for purpose and creates challenges in terms of clarity of responsibilities and accountabilities.

58 Board and committee meetings are conducted appropriately and effectively, but there is scope to further improve the quality of papers and upload minutes to the Health Board's website in a timely manner. The Health Board takes a number of actions to promote public transparency of Board and committee business. Board and committee meetings are in person and can be attended by the public, and the health board livestreams its board meetings, although there is potential to extend this practice to committees. The Health Board demonstrates a clear commitment to

hearing from patients via reports and patient and staff stories, however, there is a need to formalise its approach to Board visits to services.

59 The Health Board's Standing Orders are up to date, however, more work is needed to address weaknesses in its arrangements for registering declarations, gifts and hospitality and to address the significant backlog of policies which are overdue for review.

Corporate systems of assurance

60 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

61 My work found that **whilst the Health Board is making reasonable progress in strengthening its systems of assurance, there is more to do in relation to the Board Assurance Framework and ensuring systems of assurance are fully owned and utilised to drive improvements across the organisation**.

62 The Health Board is in the process of developing a new Board Assurance Framework (BAF). While the current approach aligns to the strategic priorities of its previous Annual Plan, there is a need for a stronger approach to identify and mitigate the risks to achieving the Health Board's strategic objectives. At present this is made more difficult because the strategic objectives are too high level and not SMART[2]. Board and committee meetings demonstrate constructive challenge to ensure risks are clearly articulated and that actions to mitigate risks are in place. However, many of the highest scoring risks have remained static and not materially lowered over time.

63 The Health Board continues to embed the Integrated Performance Framework, that was approved in September 2023. The Framework appropriately outlines roles and responsibilities across the organisation and internal escalation arrangements. The Health Board continues to refine its committee and Board performance reports which has led to some useful improvements, including statistical analysis.

64 The Health Board is developing new systems which have the potential to improve quality arrangements, and there is evidence of it making positive progress in responding to complaints in a timely way. The Quality, Safety, and Experience Committee provides good oversight the quality and safety of services. Its meetings have been extended to allow more time to cover key agenda items, and the new integrated quality report provides a broader range of quality assurance. The

[2] specific, measurable, achievable, relevant and time-bound

Auditor General plans to review the Health Board's quality governance arrangements in more detail in 2025.

65 The Health Board is strengthening its arrangements for audit recommendation tracking. The Health Board conducted a thorough and comprehensive review of recommendations from Internal Audit and Audit Wales reports going back several years. While some recommendations are superseded, for those that remain open, the Health Board has agreed revised and realistic implementation dates assigning new 'recommendation owners' where needed. As part of this work, and providing future updates, Executive Leads will need to provide better evidence on the actions taken in response to the recommendations.

Corporate approach to planning

66 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium Term Plan; and
- overseeing the delivery of corporate strategies and plans.

67 My work found that **the Health Board is planning to develop sustainable long-term organisational and clinical plans; however, to support this work, it will need to strengthen its approach to planning and ensure that plans are achievable.**

68 The Health Board is replacing its 10-year strategy - 'Living Healthier, Staying Well' 2018-28 - due to the significant external and internal changes that have occurred since its development in 2018, including the impact of COVID-19, considerable Board turnover, and changing workforce challenges. While there is a clear need for strategy refresh, there is also a fundamental need for a clinical plan (or plans), linked to sustainable service models and emerging wider organisational strategy. Clinical leadership is essential to take this forward, but currently presents a challenge for the Health Board, as does wider corporate planning capacity.

69 The Health Board also needs to strengthen its arrangements for ensuring sufficient internal and external engagement in the development of key corporate strategies and plans. While the Health Board adopted a 'bottom up' collation of service plans from across the organisation to inform development of the 2024-25 annual plan, overall engagement was limited, and particularly noted at Board level. The Health Board is planning for greater board member engagement in the development of its 2025-26 annual plan.

70 The actions in the Health Board's Annual Plan for 2024-25 do not contain sufficiently clear milestones to help monitor delivery. Furthermore, given the number of actions carried forward into the 2024-25 Annual Plan and progress to date, there is a risk that delivery will become further off-track.

Corporate approach to managing financial resources

71 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;
- overseeing financial management; and
- overseeing financial performance.

72 My work found that **whilst there are improvements in the Health Board's approach to financial management and delivery of savings, significant challenges remain in terms of spending within budget. The Health Board was not able to meet its statutory financial duties for 2023-24 despite significant financial assistance from Welsh Government. Whilst the Health Board is predicting it will achieve its financial targets for 2024-25, this will be challenging and is also reliant on several one-off savings.**

73 The Health Board did not meet its financial objectives and duties for 2023-24 as it reported a year-end deficit of £24.3 million. This is despite the Health Board receiving £82 million strategic assistance funding to support sustainable improvements in key services and £27 million cash-only support from Welsh Government during 2023-24. The Health Board is currently unlikely to achieve financial breakeven in 2024-25, although its position looks to be improving and is expected to achieve its financial control total set by the Welsh Government.

74 The Health Board demonstrates good awareness of its financial risks but needs to adopt a more transformational approach to cost improvement. This is limited by the absence of a long-term plan for services. The Health Board is strengthening its savings delivery led by the Value and Sustainability Board and underpinning workstreams. The Health Board is committing to further embed value-based healthcare, which is needed because it is currently over-reliant on shorter-term non-recurrent saving and needs to move towards a more sustainable footing.

75 The Audit Committee continues to provide oversight of compliance of SFIs and the Scheme of Reservation and Delegation. It also oversees and scrutinises information on losses and special payments, counter-fraud activity, procurement controls, and single tender actions. Strengthened financial controls are leading to fewer single tender actions and special payments. The Health Board submitted draft financial statements for 2023-24 for audit within the required Welsh Government timeframe. Whilst the quality of these significantly improved in 2023-24, there remains scope to improve the accuracy of the associated Remuneration Report. Financial reports to the Performance, Finance, and Information Governance Committee and the Board are timely, comprehensive, and transparent that support scrutiny and oversight. They provide good analysis on areas of spending, overspending, and financial expenditure trends.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2024.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2024
Opinion on the Financial Statements	July 2024
Audit of Financial Statement Report on Charitable Fund	January 2025
Opinion on the Financial Statements of the Charitable fund	January 2025
Performance audit reports	
Unscheduled Care: Flow out of Hospital – North Wales	February 2024
Discharge Planning: Progress Update	February 2024
Review of Cost Savings Arrangements	September 2024
Structured Assessment 2024	December 2024
Other	
2024 Audit Plan	April 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Planned Care Services Recovery	March 2025
Urgent and Emergency Care – Arrangements for Managing Demand	April 2025
Use of the Welsh Government's strategic financial allocation	May 2025
Review of Digital Transformation	June 2025
Quality Governance Follow up: This work has not yet started. It is our intention move this review into the 2025 audit plan. This would result in partial refund against the 2024 fee. I will set out these intentions within my 2025 Audit Plan.	June 2025

Appendix 2

Audit fee

The 2024 Audit Plan set out the proposed audit fee of £513,256 (excluding VAT).

My latest estimate of the actual fee indicates that there will be some additional charges relating to the additional work required to deliver the financial audit. There will also a partial refund against the 2024 performance audit fee. The performance audit refund relates to my intention to move the 2024 review quality governance to the 2025 Audit Plan. We will discuss the exact amounts with senior officers of the Health Board.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board's 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	On a sample basis, my team tested both journal entries and accounting estimates and found no evidence of the management override of controls.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.27]. We have noted below the financial pressures faced by the Health Board and there is a risk that cut off will not be correctly applied to funding received around the year end.	The audit team will: • agree funding received around the year end has been included within the correct year; • confirm Welsh Government funds not utilised in year have been treated correctly; and • consider the completeness of miscellaneous income.	On a sample basis, my team considered the cut off and completeness of miscellaneous income and agreed the treatment of Welsh Government funding. No issues were identified.
There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10].	The audit team will: • substantively test all material areas of pay and non-pay expenditure;	Sample testing and review that my team carried out on those areas deemed at risk of material misstatement. No issues were identified.

Audit risk	Proposed audit response	Work done and outcome
We have noted below the financial pressures faced by the Health Board and there is a risk that cut off will not be correctly applied to expenditure incurred around the year end.	• review the basis of accruals for any estimation bias; • review the year-end cut-off of expenditure; • review the basis of new provisions and changes in provision levels in year; and • review the amendments made to brought forward balances to ensure valid.	
The Health Board is under significant pressure to achieve the year end position agreed with Welsh Government of a £20 million deficit. The reported February 2024 actual position was a £9.7 million deficit with a forecast year end deficit of £33.0 million. Despite this forecast, the Health Board is confident that it will achieve a year end deficit of £27 million following confirmation of additional Welsh Government funding of £5.7m for Continuing Health Care (CHC). The current financial pressures increase the risk that management judgements and estimates could be biased to achieve the agreed year end out turn and the financial duty. The Health Board met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23. If the Health Board fails	The audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.	General audit testing, and particularly on those areas deemed vulnerable to reporting bias, did not identify any evidence of manipulation or bias.

Audit risk	Proposed audit response	Work done and outcome
to meet this financial duty in 2023-24, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.		
From 1 December 2023, the Losses and Special Payments Register (LaSPaR) which is used to calculate the losses and many of the provisions balances in the accounts has been de-commissioned. For the remainder of 2023-24, a model excel spreadsheet will be used to record losses, special payments and to calculate year-end balances. There is a risk that the transactions and balances related to losses and special payments are materially misstated due to: • the data transfer between the LaSPaR system and the excel model not being complete and accurate; and • the excel model miscalculating balances, due to spreadsheet/modelling errors and/or incorrect data entry.	The audit team will: • test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets; • consider the design and implementation of controls (if any) in place to mitigate error; • review the year-end spreadsheet to ensure that there are no significant errors or issues in the compilation of figures for the accounts; and • review transactions back to supporting evidence (e.g. Quantum reports) on a sample basis.	My team carried out a reconciliation between the LaSPaR system and the excel based spreadsheets, and on a sample basis tested the transactions within the year and no issues were identified.
The Remuneration Report contains important disclosures required by Welsh Government and accounting standards.	The audit team will review the disclosures to ensure they are in line with our understanding of the changes that have occurred during the year and that they are complete and accurate.	My audit team identified significant errors in the disclosures within the Remuneration Report which were subsequently amended by the Health Board.

Audit risk	Proposed audit response	Work done and outcome
The 2022-23 Remuneration Report was submitted for audit after the Health Board requested an extended deadline that was agreed with Welsh Government. It also required a significant number of amendments to ensure the information reported was factually accurate There have been significant changes to the composition of Senior Management and Independent Members during the year which will need to be accurately reflected within the Remuneration report.		Testing carried out on the Remuneration Report also highlighted several areas where governance arrangements needed to be improved by the Health Board.
The draft financial statements submitted for audit in 2022-23 were not of the quality we expected. The working papers received to support key disclosures in the financial statements (for example Property Plant and Equipment and Right of Use Assets) were poor and lacked a clear audit trail. Our audit work identified significant issues and errors which led to amendments to the accounts or the need for additional audit work. This impacted on the timely delivery of our audit and the submission of the audited financial statement to Welsh Government.	The audit team have been working with the Health Board's finance team to understand the arrangements and processes established to improve the quality of the draft financial statements. The audit team will monitor the closedown plan and review the draft financial statements and working papers following receipt on 3 May 2024 to identify whether there are any issues that could impact on the audit timetable.	My team noted there was a significant improvement in the quality of the draft financial statement presented for audit. This is illustrated by the relatively small number of misstatements that were identified and amended and the fact that there are no unadjusted misstatements arising from the audit. As a result, the audit was delivered on time and I signed the Financial Statements opinion on 12th July 2024.

Audit risk	Proposed audit response	Work done and outcome
The deadline set by Welsh Government for the submission of the 2023-24 audited financial statements has been brought forward to 15 July 2024. If improvements are not made there is a risk that the deadline for submission will again not be met.		

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

Archwilio Cymru
Audit Wales

Betsi Cadwaladr University Health Board – Detailed Audit Plan 2025

Audit year: 2025 – Audit of the 2024-25 accounts

Date issued: February 2025

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Contents

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Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 23) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about Betsi Cadwaladr University Health Board (the Health Board) to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

represents 1% of gross expenditure based upon 2023-24 audited financial statements.

£23.2 million

Performance materiality

represents 75% of materiality.

£17.4 million

Reporting threshold (trivial)

represents 5% of materiality.

£1.1 million

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report	Related party disclosures (individuals)
£5,000	£1,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Risk of fraud in expenditure recognition

There is a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk [Practice Note 10].

The Health Board is experiencing significant financial pressures. At the end of October 2024, it was reporting a year to date deficit of £21.4 million with a forecast year end deficit of £19.8 million.

As part of Welsh Government support for continued demand and inflationary pressures, it provided additional funding to the Health Board of £11.15 million in December 2024. Conditions attached to this allocation mean that the Health Board must deliver a deficit of £8.6 million or better in 2024-25, with elements of future funding reliant on this year-end result.

The position at the end of December 2024 shows a year-to-date deficit of £14.8 million and a forecast year-end deficit of £8.6 million.

The current financial pressures increase the risk that management judgements and estimates could be biased to achieve the agreed year-end outturn and its financial duty.

There is a risk that cut off will not be correctly applied to expenditure incurred around the year end to ensure successful delivery of the year-end target.

Our planned response

My audit team will:

- substantively test all material areas of pay and non-pay expenditure;
- review the basis of accruals for any estimation bias;
- review the year-end cut-off of expenditure;
- review the basis of new provisions and changes in provision levels in year; and
- review the amendments made to brought forward balances to ensure valid.

Failure of first financial duty

There is a significant risk that the Health Board will fail to meet its r first financial duty to break-even over a three-year period. As noted above, the position at the end of December shows a year-to-date deficit of £14.8 million and a forecast year-end deficit of £8.6 million. This, combined with the outturns for 2022-23 and 2023-24, predicts a cumulative three-year deficit of £32.6 million.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Your current financial pressures increase the risk that management judgements and estimates could be biased to achieve the financial duty.

Our planned response

The audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.

Governance arrangements of senior officer appointments

The regularity opinion was qualified in 2022-23 and 2023-24 due to the Health Board incurring irregular expenditure and breaching its standing financial instructions in making payments to former interim executive members of the Board at a higher rate than the Welsh Government's approved salary at the relevant pay band.

We also identified other weaknesses with the Health Board's 's governance arrangements over senior appointments with a lack of documentation to support appointments prior to officers starting i their roles.

Due to the number of changes to interim and permanent appointments, there is a risk that such weaknesses in control continue to arise with a risk that the regularity opinion is again qualified.

Our planned response

The audit team is currently working with the Director of Corporate Governance and her team to identify and review all senior appointments during 2024-25 to ensure all governance procedures were followed and evidenced.

Remuneration report disclosures

There have been several new permanent and interim appointments to senior officer posts and board member positions during 2024-25 which need to be accurately captured in the remuneration report.

We identified significant material errors within the 2023-24 remuneration report, all of which were amended to ensure the information reported was factually accurate.

The remuneration paid to senior officers and board members continues to be of high interest and is material by nature. There is a risk that changes in year are not appropriately disclosed in the remuneration report, and even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Health Board and the party.

The Health Board has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- review management's estimation process for the valuation of provisions;
- consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- ensure that disclosures are in accordance with HM Treasury's Financial Reporting Manual and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **January to March 2025**	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Detailed Audit Plan
Interim **March to April 2025**	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing
Fieldwork **May to June 2025**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **June to July 2025**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru Annual audit summary Post project learning

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:


Strategic planning


Asset management


Financial planning


Collaborative working


Performance and risk management


Overall governance.


Workforce planning

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

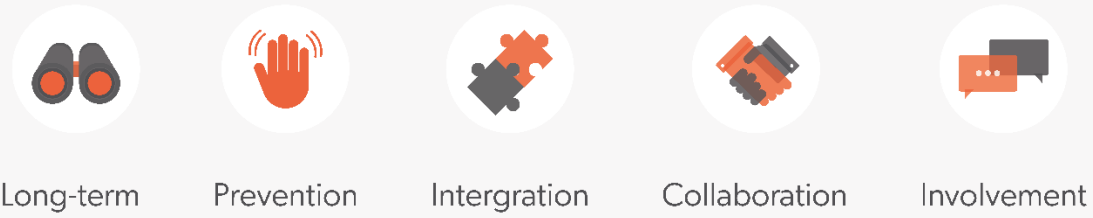
Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.

The **Sustainable development principle** is defined as acting in a manner...

...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

To do this, they must take account of the **'five ways of working'**.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my performance audit work.

Structured Assessment – core

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

As part of this work I will assess the progress the Health Board is making in taking forward its Foundations for the Future programme, its approach to service transformation planning and the refresh of its well-being of future generations objectives.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having. My review will include an assessment of the progress the Health Board has mad in implementing the recommendations from my previous work on cost improvement planning.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Structured Assessment – review of the arrangements to manage estates

Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.

Indicative timescales

Fieldwork to commence between April and May 2025 and reporting by the end of September 2025.

All-Wales thematic review of cancer services

Scope of the work

I plan to undertake work following on from my recent review of the national leadership arrangements for cancer services. Whilst the exact focus of this work is still to be determined, it is likely to consider:

- The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
- The efficacy of local plans and associated actions to recover cancer waiting lists; and
- Use of the additional Welsh Government financial allocations to improve cancer services.

Indicative timescales

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

Local project work – Quality Governance

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. The local performance audit work will focus on the quality governance arrangements in the Health Board. This audit review was originally included in the 2024 audit plan. However, as this work has not yet commenced, I have decided to transfer the review into my 2025 plan and provide a partial refund against the 2024 fee. The exact scope of the quality governance work will be determined during the audit planning process, but it is likely to include the review of the Health Board's quality strategy and plans, implementation of the Duties of Quality and Candour, the approach for responding to and tracking independent review and inspection recommendations, and quality governance and oversight arrangements.

Indicative timescales

Fieldwork to commence July 2025 and reporting by November 2025.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

An additional fee of £22,166 was charged for the 2024 financial statements audit due to additional, unplanned work which arose from numerous issues with the remuneration report and the identification of irregular payments that led to the qualification of the regularity opinion. The Health Board will receive a refund of £25,613 against the 2024 performance audit fee as a result of moving work on quality governance into this year's plan. These adjustments to the 2024 fee are shown in the figures presented in **Exhibit 2**.

Your estimated total audit fee: £521,947

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)

Estimated fee for 2025 (£)[1]		Actual fee for 2024 (£)	
Audit of financial statements	Performance audit work	Audit of financial statements[2]	Performance audit work[3]
£305,325	£216,622	£322,387	£187,422
Total fee: £521,947		**Total fee: £509,809**	

[1] The fees shown in this document are exclusive of VAT.

[2] Includes an additional fee of £22,166 in respect of additional unplanned work

[3] Includes a refund of £25,613 as a result of moving work on quality governance into the 2025 plan

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so. Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Dave Thomas dave.thomas@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Lead	Matthew Edwards matthew.edwards@audit.wales	Dave Thomas dave.thomas@audit.wales
Audit Manager	Michelle Phoenix michelle.phoenix@audit.wales	Andrew Doughton andrew.doughton@audit.wales
Audit lead	Simon Monkhouse simon.monkhouse@audit.wales Natalie Cole natalie.cole@audit.wales	Fflur Jones fflur.jones@audit.wales

I can confirm that the core members of my audit team are independent of the Health Board. Some junior members of our financial audit team do have close relations who work in the Health Board and we have put the necessary procedures in place for these staff to safeguard our independence and objectivity.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Audit Wales

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Teitl adroddiad: ***Report title:***	Local Counter Fraud Service Q3 Report 2024/2025 & Annual Workplan 2025/2026 - PUBLIC			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 04 March 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide assurance to the Audit Committee around the progress of the Local Counter Fraud Service for the Health Board by way of a quarterly report. This Local Counter Fraud Workplan for 2025/2026 is also provided to the Audit Committee for approval which sets out the programme of counter fraud work to be undertaken during the financial year, to protect NHS financial resources. The workplan is in line with the NHS Requirements of the UK Government Functional Standard 013 Counter Fraud (GovS013) from the Cabinet Office and is set to the four key principles of NHS Counter Fraud Authority. Finally, the revised version of the F03 Counter Fraud, Bribery and Corruption Policy is included for approval.			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to consider and note the contents of the Q3 report. The Committee is also asked to approve the Counter Fraud Annual Workplan for 2025/2026 and the revised F03 Counter Fraud, Bribery and Corruption Policy.			
Arweinydd Gweithredol: ***Executive Lead:***	Mr. Russell Caldicott – Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Ms Danielle Kerr-Timmins – Head of Local Counter Fraud Service			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The previous Local Counter Fraud Service Workplan for 2024/25 was approved by the Audit Committee on 7 May 2024
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress against the Local Counter Fraud Service Workplan for 2024/25 will be reported to the Audit Committee and also to Welsh Government in the Counter Fraud Annual Report for 2024/25.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption. Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
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?***	No Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions. Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The programme of Counter Fraud work targets the NHS Requirements of the UK Government Functional Standard 013 Counter Fraud (GovS013) from the Cabinet Office, to protect NHS financial resources from Fraud, Bribery and Corruption.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No recommendations

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been subject to Executive review and sign off.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	1. Risk of significant financial loss due to Salary Overpayments (Risk Register 2601) 2. Potential Loss of income to Overseas Visitor Patients (Risk Register 3058) 3. General Medical Services - Capitation /Patient Registration Fees (Risk register 3061) 4. Pharmaceutical Fraud (Risk Register 3064) 5. Private Patients (Risk Register 3060) 6. Cyber Enabled Salary Diversion (Risk Register 4165) 7. Continence Services (Risk Register 4170) 8. Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171) 9. Hospital Mortality Services (Risk Register 4172)
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A

Next Steps:

The Committee is required to note the contents of the Q3 Local Counter Fraud Service Progress Report. The Committee is also asked to approve the Counter Fraud Annual Workplan for 2025/2026 ahead of the beginning of the financial year. Finally, the Committee is asked to approve the revised version of the F03 Counter Fraud, Bribery and Corruption Policy.

List of Appendices:

Appendix A – Annual Counter Fraud Workplan 2025/2026
Appendix B – Revised F03 Counter Fraud, Bribery and Corruption Policy

AUDIT COMMITTEE,4TH MARCH 2025

Local Counter Fraud Service Progress Report

1. Introduction/Background

This report is intended to provide the Audit Committee with assurance regarding the progress of the Local Counter Fraud Service. As this is an assurance-focused report, it has not been presented to any other forums for consultation prior to submission.

The purpose of this report is to inform the Audit Committee of key updates and progress in the following areas: compliance with NHS Counter Fraud Authority Standards, delivery of the Annual Workplan, ongoing and concluded investigations, training initiatives, risk management, and any other relevant developments. The Committee is invited to review and note the contents of this report.

2. Updates

2.1 All Wales Recovery of Overpayments Procedure

Counter Fraud Service Wales have developed a procedure for the recovery of overpayments which includes clear instruction on when an overpayment should be referred to LCFS for investigation. This document will be presented to the Audit Committee in due course.

2.3 Cases

There are currently 38 open cases, 16 of which are ready for closure. 6 cases have been closed in Q3.

2.4 Training

Training continues to be delivered predominantly through e-learning modules, with workbooks provided as an alternative for staff unable to access a computer. The training remains mandatory for all staff and requires updates every three years. Compliance remains high at 91.20%

Five presentations were delivered to staff during the quarter.

2.5 Policy

The review of F03 Counter Fraud, Bribery and Corruption Policy was agreed by the Executive Policy Oversight Group on the 23rd of January 2025.
The Policy has been presented to members of the Executive Committee. Audit Committee members are invited to review the contents of the policy and are asked to approve the document.

A copy of the policy document can be found in appendix B.

2.6 Proactive Work

- There were 37 media reports or news articles / fraud deterrence activities published in Q3, up significantly from the 18 in Q2.
- The Q3 Fraud Matters Newsletter was circulated electronically to Health Board staff, all primary care contractors and to North Wales Police.

- Continued to work closely with NHS Wales Shared Services Partnership (NWSSP) on Post Payment Verification of General medical Services (GMS), General Pharmaceutical Services (GPhS) and General Ophthalmic Services (GOS)
- Provided advice and assistance to line mangers, workforce colleagues and external Primary Care Contractors.

2.7 Community Pharmacy Data Matching Pilot

The Community Pharmacy Data Matching Pilot has been reviewed by the Counter Fraud Team. It is pleasing to note that the pilot did not identify any systematic fraud or errors which merited any investigation action by CFS Wales or Local Counter Fraud Specialists (LCFSs).

Since the Data Matching Pilot was ended by Audit Wales, NHS CFS Wales have not carried out any specific work relating to the risks identified during the exercise. Following the Data Matching Pilot, NWSSP have developed their own application for identifying Pharmacy outliers. A pilot exercise was started with Cwm Taf Morgannwg Health Board, in which the invoices from Pharmacy contractors were being requested to validate specify claims. NHS CFS Wales have been kept updated by PPV on the pilot and the last updated received was that the pilot is on hold for the time being due to ongoing issues and operational constraints within PPV. NHS CFS Wales will continue to liaise with PPV with regards to the pilot.
Counter Fraud and Post Payment Verification meetings take place in BCUHB quarterly where we will review the progress of this pilot exercise and review recommendations as and when they are received.
In the next meeting with PPV, we will discuss the opportunities for a local proactive exercise where necessary.

For clarity regarding BCUHB's response to the Welsh Government, as presented to the Committee in January 2025, the conclusion states:

"Opportunities to make use of Artificial Intelligence technologies to examine dispensing and claims data should be explored further by the Post-Payment Verification and Counter Fraud Teams across Wales."

The effective use of AI technology would first require the completion of widespread implementation of an electronic prescribing system. At this stage, Local Counter Fraud lacks the knowledge and expertise in AI technology to make specific recommendations. Therefore, BCUHB will await the outcomes and recommendations from the project led by Shared Services Partnership and CFS Wales. Any necessary actions arising from those recommendations can be supported by the BCUHB Counter Fraud Team.

2.8 Counter Fraud Annual Work Plan 2025-2026

This work plan sets out the key activities, objectives, and performance measures for the Counter Fraud Team for the upcoming financial year, in accordance with NHS Counter Fraud Authority (NHSCFA) requirements and the Government Functional Standard GovS 013: Counter Fraud.

It is important to note that NHS requirements may change following the submission of the functional standard return, due by 31st May 2025. In previous years, work plans were delayed until after this submission. However, to ensure effective planning, resource allocation, and alignment with organisational priorities, the 2025-2026 plan has been developed ahead of the financial year's start. Any subsequent changes to requirements will be reviewed, and the work plan will be updated accordingly.

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by the Counter Fraud is set around four key principles:

Key Principle 1: Strategic Governance
Key Principle 2: Inform and Involve
Key Principle 3: Prevent and Deter
Key Principle 4: Hold to Account

The proposed work plan for 2025-2026 ensures that all efforts of the team align with national policies, including guidance from the Welsh Government and NHS Counter Fraud Authority.

The committee are invited to review and approve the work plan, please see appendix A.

3. Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

4. Risk Management

There are 9 risks recorded on Datix linked to Counter Fraud which are:

1. Risk of significant financial loss due to Salary Overpayments (Risk Register 2601)
2. Potential Loss of income to Overseas Visitor Patients (Risk Register 3058)
3. General Medical Services- Capitation /Patient Registration Fees (Risk Register 3061)
4. Pharmaceutical Fraud (Risk Register 3064)
5. Private Patients (Risk Register 3060)
6. Cyber Enabled Salary Diversion (Risk Register 4165)
7. Continence Services (Risk Register 4170)
8. Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171)
9. Hospital Mortality Services (Risk Register 4172)

5. Equality and Diversity Implications

Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption

Local Counter Fraud Service Work Plan 2025-2026

1. Introduction/Background

This work plan sets out the key activities, objectives, and performance measures for the Counter Fraud Team for the upcoming financial year, in accordance with NHS Counter Fraud Authority (NHSCFA) requirements and the Government Functional Standard GovS 013: Counter Fraud.

It is important to note that NHS requirements may change following the submission of the functional standard return, due by 31st May 2025. In previous years, work plans were delayed until after this submission. However, to ensure effective planning, resource allocation, and alignment with organisational priorities, the 2025-2026 plan has been developed ahead of the financial year's start. Any subsequent changes to requirements will be reviewed, and the work plan will be updated accordingly.

2. Executive Summary

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by the Counter Fraud is set around four key principles:

Key Principle 1: Strategic Governance - to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit & Risk Assurance Committee will continue.

Key Principle 2: Inform and Involve – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud bribery and corruption in the NHS. Effective use of multi-media channels in order to reach staff across the Health Board will be vital to effective delivery of this principle.

Key Principle 3: Prevent and Deter – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.

Key Principle 4: Hold to Account - to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated.

The proposed work plan for 2025-2026 ensures that all efforts of the team align with national policies, including guidance from the Welsh Government and NHS Counter Fraud Authority.

KEY PRINCIPLE	TASK	DESCRIPTION	TIMELINE
STRATEGIC GOVERNANCE - to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit & Risk Assurance Committee will continue.	Workplan	Annual workplan to be agreed by Executive Director of Finance, Executive Committee and Audit Committee and to be reviewed following the submission of the Counter Fraud Functional Standard Return, or following any changes to NHS requirements.	Prior to commencement
	Accountable Board Member	Executive Director of Finance to continue the role of accountable board member and ensure that nominations to the NHS Counter Fraud Authority for accountable board member, audit committee chair, counter fraud champion and Local Counter Fraud Specialists are up to date and that any changes to nominations are reported to the NHS Counter Fraud Authority.	Q1
	Audit Committee Agenda	Counter Fraud to remain a standing agenda item for Audit Committee (both public and private).	Bi-monthly in line with Audit Committee timeline
	Case Updates and Recommendations	Ensure transparency and good governance by including summary of cases and recommendations/lessons learnt to Private Audit Committee Sessions by way of quarterly and annual progress reports.	Quarterly
	Stakeholder Engagement	Quarterly meetings to be held between Head of Local Counter Fraud and the following responsible persons:	Quarterly

		- Executive Director of Finance (or Director of Finance in their absence). - Director of Governance - Counter Fraud Champion - Chair of the Audit Committee - Head of Internal Audit (or deputy in their absence).	
	All-Wales Collaboration	A representative of the Betsi Cadwaladr University Health Board Counter Fraud Team will be in attendance at All Wales Counter Fraud meetings to ensure updated intelligence gathering.	Monthly
	Stakeholder Engagement	A member of the Counter Fraud Team will attend stakeholder meetings such as the Controlled Drugs Liaison Network, partnership meeting with North Wales Police and regular meetings with Security Advisory Team.	Quarterly
	Compliance with NHFCFA requirements	Head of Local Counter Fraud to prepare and submit Counter Fraud Functional Standard Return annually and include this in the Annual Report with the appropriate signed statement of assurance, to present to Audit Committee.	Q4
	Governance	Update the information sharing protocol with People & Organisational Development with the assistance of the Information Governance Team.	Q2
	Policy	Ensure that the F03 Counter Fraud, Bribery and Corruption Policy remains up to date by way of constant review and amendment of	Q1 and Ongoing

		F03 Counter Fraud, Bribery and Corruption Policy where necessary as per Risk Management Framework RM01	
INFORM AND INVOLVE – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud bribery and corruption in the NHS. Effective use of multi-media channels in order to reach staff across the Health Board will be vital to effective delivery of this principle.	Communications Strategy	Develop a Counter Fraud Communications Strategy in line with Corporate Communications to ensure effective promotion of a Counter Fraud Culture across BCUHB. This will include: - Review of the Counter Fraud BetsiNet page and support support communications, promote the refreshed F03 Counter Fraud, Bribery and Corruption Police and staff responsibilities. - Development of 12 Counter Fraud news articles to be circulated to staff using BetsiNet and Viva Engage in order to inform staff about relevant fraud, bribery and corruption risks and include 'goof news' deterrence articles. - 4 Fraud Clinics to be conducted across the Health Board annually to ensure all staff have access to information and reporting mechanisms and to measure staff awareness of the F03 Counter Fraud, Bribery and Corruption Policy. - Payslip messages each quarter relating to fraud risks such as salary overpayment. - Promotion of the refresh to the F03 Counter Fraud, Bribery and Corruption Policy including quarterly 'did you know' articles to be disseminated to staff.	Q1
	Audit	Engage with Internal Audit to share areas of concern relating to Fraud, Bribery and Corruption. Use of data and information gained from this engagement will be used to shape local proactive exercises and a targeted approach to Counter Fraud.	Q2
	Training	Maintain at least 85% compliance for Fraud Awareness E-Learning and report compliance to Audit Committee	Quarterly

	Training	Review of the Counter Fraud presentation programme resulting from feedback.	Q1
	Survey	Conduct a Counter Fraud Awareness survey to determine the level of fraud awareness within the organisation and to review results to direct corrective and preventative measures to ensure a lower level of risk to economic crime for BCUHB.	Q3
	Feedback Form	Implement a Microsoft office feedback form and embed a link to the Counter Fraud BetsiNet page to ensure staff have a mechanism to provide feedback at all times. This will NOT be an online reporting mechanism.	Q3
PREVENT AND DETER – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.	Local Proactive Exercises	Utilise Intelligence and lessons learnt to complete at least two local proactive exercises relating to fraud, bribery and corruption risks. Details of exercises to be added to the CLUE case management system and a record made of any financial recovery or loss prevention as a result of the exercise. A local proactive exercise will be completed in relation to consultant job plans, any other local proactive exercise conducted will be in response to specific identified risks throughout the financial year.	Q2 and Q4
	Controlled Document Fraud proofing	Engage with Executive Policy Oversight Group and Integrated Assessment Screening Tool for Policy to ensure that any new or reviewed control documents have consideration for Fraud, Bribery and Corruption risks.	Q2

	Intelligence Sharing	Disseminate all intelligence received by the Counter Fraud Team to the appropriate responsible persons within 14 days of receipt (this will include all Fraud Prevention Notices) and provide recommendation.	As and when received
	Risk Assessment and Mitigation	Record assessed Fraud, Bribery and Corruption risks on the Corporate Risk Register as and when identified in line with the Health Board's Risk Management Framework and provide updates on progress towards mitigation in line with the framework.	Monthly
HOLD TO ACCOUNT - to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated.	Investigation Performance	All new investigations to be triaged and an action plan for investigation added to the CLUE case management system within 30 days of allocation.	Ongoing
		80% of total cases assigned to LCFS will reach either conclusion decision or charge within 12 months (unless remaining open whilst awaiting repayment).	Ongoing
		Appropriate use of CLUE, the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements to include regular progress updates.	Ongoing
	Sanction and Redress	Ensure the application of sanctions in line with legislation. Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the circumstances of each case.	Ongoing

F03 Version 6.0

LOCAL COUNTER FRAUD, BRIBERY AND CORRUPTION POLICY

Author & Title	Head of Local Counter Fraud Service Deputy Head of Local Counter Fraud Service				
Responsible Dept / director:	Finance Department / Executive Director of Finance				
Approved by:	Executive Policy Oversight Group – 23/01/2025 Executive Team Meeting – [date] Audit Committee – [date]				
Date approved:	xxxxxxxxxxxxxx				
Date activated (live):	xxxxxxxxxxxxxx				
Documents to be read alongside this document:	All Wales Procedure for NHS Staff to Raise Concerns WP4A Code of Conduct - Disciplinary Rules and Standards of Behaviour WP6 BCUHB Risk Management Framework RM01 All Wales Disciplinary Policy WP9 Upholding Professional Standards Wales NHS Wales Managing Attendance at Work Policy WP11 Standards of Business Conduct OBS02 Private Practice Policy MD14				
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First operational:	January 2025				
Previously reviewed:	2021				
Changes made yes/no:	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. The Intranet should be referred to for the current version of the document

CONTENTS

1. INTRODUCTION/OVERVIEW

This policy is necessary to ensure the prevention of loss of NHS resources through fraud, bribery and corruption. The policy demonstrates the Health Board's commitment to supporting the public service values of accountability, probity and openness and, in particular, recognises the need to ensure the highest standards by pro-actively reducing the risk of NHS fraud, bribery and corruption.

2. POLICY STATEMENT

Betsi Cadwaladr University Health Board (BCUHB) is committed to minimising fraud, bribery, and corruption within the NHS to safeguard public funds and maintain resources for patient care. Fraud undermines public trust and reduces the resources available for frontline services. BCUHB recognises that the vast majority of NHS workers and employees act with integrity, there are some instances where this is not the case. BCUHB adopts a zero-tolerance approach to fraud, bribery and corruption will actively pursue disciplinary, regulatory, civil, and criminal actions against offenders as appropriate and in the public interest on every occasion.
Aligned with statutory authorities and public service values of accountability, probity, and openness, BCUHB prioritises robust prevention, investigation, and prosecution measures to combat fraudulent activities. This policy is endorsed by the Executive Board and reflects the organisation's dedication to maintaining the highest standards of integrity to protect and enhance NHS services for the people of North Wales.

3. AIMS/PURPOSE

This policy aims to:

- Safeguard public funds by reducing fraud, bribery, and corruption within the Health Board.
- Foster a culture of integrity, transparency, and accountability across the organisation.
- Ensure compliance with legal and regulatory obligations related to the prevention, detection and investigation of fraud, bribery and corruption.
- Protect staff and workers who suspect fraud, bribery, or corruption, providing a safe reporting process in accordance with the All Wales Procedure for NHS Staff to Raise Concerns and the Public Interest Disclosure Act (1998).
- Preserve resources for their intended purpose of delivering high-quality patient care.
- Minimise fraud, bribery, and corruption to the lowest possible level and maintain that standard

4. OBJECTIVES

The objectives of this policy are to:

- Enhance understanding of fraud, bribery, and corruption through comprehensive training and guidance.
- Provide clarity on operational arrangements, including collaboration with NHS Counter Fraud Service Wales and the NHS Counter Fraud Authority (NHS CFA).
- Establish clear roles and responsibilities to ensure accountability.
- Ensure compliance with the Government Functional Standard GovS 013: Counter Fraud, relevant legal frameworks, and ethical obligations, including but not limited to:

    - The Criminal Procedure and Investigations Act (CPIA) 1996
    - The Fraud Act 2006
    - The Bribery Act 2010
    - The Economic Crime and Corporate Transparency Act 2023
    - The Police and Criminal Evidence Act 1984 Codes of Practice
    - Welsh Government Directions to NHS Bodies on Counter Fraud Measures (1st December 2005)

5. SCOPE

The policy applies to all employees and workers of the Health Board, regardless of position held, as well as consultants, vendors, contractors, and/or any other internal and/or external stakeholders, who have a business relationship with the Health Board.
Where applicable, this policy will also apply to persons who do not work for BCUHB in any capacity, but are suspected to have committed an offence of fraud, bribery or corruption against the Health Board.

6. ROLES AND RESPONSIBILITIES

6.1 Chief Executive Officer and The Board

The Chief Executive Officer has the overall responsibility for funds entrusted to the organisation. This includes a requirement to deal with instances of fraud, bribery and corruption. The Chief Executive Officer must ensure adequate policies and procedures are in place to protect the organisation and the public funds entrusted to it.

In order to meet the requirements Government Functional Standard GovS013 on Counter Fraud, The Executive Director of Finance will nominate an individual Counter Fraud Champion. The individual should be of sufficient seniority to be able to communicate and have access to the whole organisation.

The Board is responsible for maintaining a named person nominated to act as its Local Counter Fraud Specialist. This person will usually be the Head of Local Counter Fraud Service for BCUHB. The Board will also ensure commitment to

tackling fraud, bribery and corruption at top level and will have final approval over this policy.

The Board will be committed to preventing associated persons from committing fraud. They will foster a culture within the organisation in which fraud is never acceptable and should reject profit based on, or assisted by, fraud.
This will include:

- Communication and endorsement of the organisation's stance on preventing fraud, including mission statements.
- Ensuring that there is clear governance across the organisation in respect of the fraud prevention framework.
- Commitment to training and resourcing.
- Leading by example and fostering an open culture, where staff feel empowered to speak up if they encounter suspected fraudulent practices.

Non-executive board members will provide independent judgement, external perspectives and advice, and will work to ensure that the Health Board's stance on matters related to fraud, bribery and corruption are in line with the seven principles of public life (Nolan Principles) as follows; selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

6.2 Audit Committee

The Audit Committee is responsible for seeking assurance that the organisation has adequate arrangements in place for countering fraud and bribery and compliance with NHS CFA Standards.

The Audit Committee will:

- Review and approve the Annual Counter Fraud Workplan objectives and monitor the progress via Quarterly and Annual Progress Reports.
- Provide a summary report of Audit Committee activity to the Executive Team, to strategically support the counter fraud process.
- Continue to review controls and systems which ensure compliance with financial instructions.
- Report any identified weaknesses in systems or controls which pose a risk of fraud/bribery/corruption to the Executive Director of Finance.
- Report any instances of potential or suspected fraudulent activity identified during the course or their work or from other sources to the Executive Director of Finance.

6.3 Executive Director of Finance

The Executive Director of Finance will be the Health Boards nominated Accountable Individual for matters related to Fraud, Bribery and Corruption. They will have responsibility for the strategic management of Health Board's Local Counter Fraud Service and may delegate the operational management of the Local Counter Fraud Service team to their deputy.

The Executive Director of Finance will:

- Monitor compliance with the Counter Fraud Functional Standards for the Health Board.
- Inform the board of all matters for escalation relating to fraud, bribery and corruption, including but not limited to cases where serious loss has occurred, where media interest may be heightened or where the organisation is deemed to be at serious risk of loss.
- Ensure appropriate financial procedures and systems are embedded to ensure that any financial loss to the organisation through fraud, bribery and corruption is kept to a minimum.
- Ensure the required documentation is provided to NHS CFA to support the nomination process for the Health Board's Local Counter Fraud Specialists, Counter Fraud Champion, Accountable Board Member (themselves) and Chair of the Audit Committee.
- Report to the Health Board's Executive Board on the adequacy of internal financial control and risk management including exposure to economic crime.
- Be accountable for the organisation's performance in countering fraud, bribery and corruption.
- Ensure the board has discussions on the nature of the fraud, bribery and corruption risk facing the organisation and the measures being taken to mitigate this risk.
- Ensure the organisation has the resources, skills and capability to deliver the NHS CFA counter fraud, bribery and corruption strategy.
- Ensure the organisation has clear lines of accountability for fraud risk and loss across all levels of the organisation.
- Ensure adequate policies and procedures are in place to protect the organisation and the public funds entrusted to it, which will ensure that the Health Board works effectively to prevent fraud, bribery and corruption wherever possible.

6.4 Executive Director of People and Organisational Development

The Executive Director of People and Organisational Development will ensure:

- Joint working with the Executive Director of Finance to ensure processes are in place to allow for cohesive working for investigations which include disciplinary or upholding professional standards, fraud/bribery/corruption related matters. This will include the adherence to any joint working protocol between People and Organisational Development and Local Counter Fraud Service.
- That Local Counter Fraud Service are informed at an early stage of any matters relating to fraud/bribery/corruption.

6.5 Counter Fraud Champion

The Counter Fraud Champion should promote awareness of fraud, bribery and corruption within the organisation, and inform process improvements and drive cultural change.

The role of the Counter Fraud Champion is to:

- Understand the threat posed by fraud, bribery and corruption by monitoring the intelligence provided as part of NHS CFA's strategic intelligence assessment.
- Raise any successes, concerns or opportunities for improvement with the Executive Director of Finance and/or Audit Committee Chair.
- Support the Lead Counter Fraud Specialist (Head of Local Counter Fraud Service) in ensuring that all information relating to fraud is recorded and reported appropriately.

6.6 Head of Local Counter Fraud Service and Local Counter Fraud Specialists (LCFS)

In line with the Government Functional Standard GovS013, the Executive Director of Finance will nominate a Lead Local Counter Fraud Specialist (LCFS), usually the Head of Local Counter Fraud Service within the Health Board will undertake this role, however in their absence, another LCFS can be nominated as the lead. The Local Counter Fraud Team will be made up of accredited LCFS staff.

The BCUHB Counter Fraud Team will investigate matters involving Fraud, Bribery and Corruption. Where other crimes are reported such as theft, the BCUHB Security Advisory Team can be consulted for advice.
Such matters should be, where appropriate, reported to Police for investigation. The Health Board's People and Organisational Development Team should be consulted in matters which may have a disciplinary element.

The Local Counter Fraud Team will:

- Be responsible for conducting criminal investigations into allegations of fraud, bribery and corruption where a criminal offence is suspected to have been committed. In line with Police and Criminal Evidence Act 1984 (PACE) and the Criminal Procedure and Investigations Act 1996 (CPIA). Instructions outlined in the NHS CFA Fraud and Corruption Manual will be followed and confidentiality will be respected during the course of the investigation process.
- Retain direct access to the Executive Director of Finance as and when required, to ensure compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures.
- Meet privately with the Chair of the Audit Committee on a quarterly basis, to ensure compliance with good governance arrangements and emerging risks of fraud, bribery or corruption facing the Health Board.
- Work in accordance with the Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements, the NHS Counter Fraud Authority Quality Assurance Programme (which includes the annual submission of the Counter Fraud Functional Standard Return), the Government Functional Standard 013 for Counter Fraud (GovS013) and the NHS Counter Fraud Authority (NHS CFA) Strategy.
- Ensure compliance with relevant legislation and guidance such as the Criminal Procedure and Evidence Act 1996, the Police and Criminal Evidence Act 1984 Codes of Practice and the Attorney General's Guidelines on Disclosure.

- Adhere to the Counter Fraud Professional Accreditation Board (CFPAB) Principles of Professional Conduct as set out in the NHS CFA Fraud and Corruption Manual.
- Have responsibility for undertaking fraud investigations within NHS Wales and ensuring that all appropriate sanctions are considered and imposed which may include criminal prosecution, civil proceedings or disciplinary sanction, or a combination of all three sanctions. All cases considered for prosecution will be discussed by the Head of Local Counter Fraud Service and the Head of CFS Wales. The approval of the Executive Director of Finance will be required before the case is referred, via CFS Wales to the Specialised Fraud Division of the Crown Prosecution Service.
- Work to recover funds where a loss has occurred at every available opportunity.
- Ensure a programme of proactive counter fraud work is undertaken to prevent and detect cases of fraud, bribery and corruption including ensuring that the Health Board is aware of and appropriately acts upon any Fraud Prevention Notices.
- Work to identify system weaknesses, and make recommendations to ensure that the Health Board is protected in the future and that good governance procedures are in place, this will include the undertaking of fraud risk assessments.
- Complete quarterly and annual progress reports to be submitted to the Audit Committee alongside an Annual Counter Fraud Workplan, which is to be approved by the Audit Committee.
- Ensure appropriate recording of incidents and timely updates on investigative measures on the CLUE case management system.
- Promote a pro counter fraud culture within the Health Board.
- Provide advice and information to BCUHB staff at all levels in matters relating to Fraud, Bribery and Corruption to minimise the risk to the Health Board.

6.7 All Managers

All managers must:

- Ensure that policies, procedures and processes within their area of work are adhered to and kept under regular review.
- Work to establish a counter fraud culture within their team and ensure that staff have access to and understanding of this document and supporting policies.
- Take all allegations of fraud, bribery and corruption seriously and ensure immediate reporting to the BCUHB Counter Fraud Team.
- Work with the BCUHB Counter Fraud Team and People and Organisational Development to ensure that evidence is provided to support any investigation on their request.
- Take steps at the recruitment stage to establish, as far as possible, the previous employment record of potential employees, as well as the verification of required qualifications and memberships of professional regulatory bodies. In this regard, temporary and fixed-term contract employees will be treated in the same manner as permanent employees.
- Work to identify and assess risks of fraud, bribery and corruption within their area of control and ensure adequate control measures are in place to minimise the risk to the Health Board.

- Ensure all staff complete mandatory training in relation to Fraud, Bribery and Corruption.
- Ensure that all staff under their control adhere to requirements to declare business interests.

6.8 All Workers/Employees

This section is intended to cover all employees and workers which may include: Consultants, vendors, contractors, agency/locum, students on placement, volunteers and those with a business relationship with the Health Board.

All employees and workers have a responsibility to uphold the standards of business conduct for the NHS. It is understood that the vast majority of employees and workers will act with honesty and integrity. Employees and workers are also expected to act in accordance with the standards laid down by their Professional Bodies where applicable.
Employees and workers have a responsibility to work to ensure public funds are safeguarded by:

- Reading, understanding and complying with this policy and supporting documentation including local procedures and guidance. Advice should be sought from a manager or a member of the BCUHB Counter Fraud Team if staff or workers are unsure of any element.
- Completing mandatory training in relation to Fraud, Bribery and Corruption.
- Being alert to matters of fraud, bribery and corruption with the awareness that others may be attempting to deceive and reporting any suspicions (further guidance on how to report can be found in Appendix B)
- Complying with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts (including bequests in patients' Wills that become known to staff) and hospitality.
- Not requesting or receiving a bribe from anybody, nor imply that such an act might be considered. This means that you will not agree to receive or accept a financial or other advantage from a former, current or future client, business partner, contractor or supplier or any other person as an incentive or reward to perform improperly your function or activities.
- Comply with Health Board guidance regarding declarations of interest, gifts, hospitality and external employment.

7. PARTNERSHIP WORK, RESPONSE PLAN AND RISK

7.1 NHS Counter Fraud Authority and Government Functional Standard (GovS013: Counter Fraud)

The NHS Counter Fraud Authority (NHS CFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. As a health authority focused entirely on counter fraud work, the NHS CFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care (DHSC).

To ensure compliance with the Government Functional Standard 013, NHS CFA set out the NHS requirements. The Health Board will ensure compliance with these requirements and will submit an annual Counter Fraud Functional Standard Return, detailing compliance with each component.
The Health Board will also work in line with the NHS CFA Fighting Fraud Strategy, the framework of which will shape the contents of the Health Board's Annual Counter Fraud Workplan.

7.2 NHS Counter Fraud Service Wales

NHS Counter Fraud Service Wales (CFS Wales) have a remit to identify and tackle Economic Crime including Fraud, Bribery and Corruption in NHS Wales. NHS CFS Wales provide specialist criminal and financial investigation services to all health bodies in Wales.

The CFS Wales team consists of experienced investigators who deal with large scale, complex frauds, bribery and all corruption issues in NHS Wales. The team work closely with the NHS Counter Fraud Authority (CFA) in England and with other investigative bodies including the police. They also provide support and guidance to the BCUHB Counter Fraud Team.

In the event of an allegation involving a Senior Manager or Board Member, or where there would be a clear conflict of interest for internal investigation, the allegation will be referred to the Head of CFS Wales for investigation. In these circumstances all communication will be made via the Head of CFS Wales.

For the purpose of this document, a senior manager is defined as:

'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.'

Any fraud referrals which are received which involve more than one NHS health body, or cross border enquiries, will be referred to the Head of CFS Wales for investigation. The Health Board's Counter Fraud Team may be asked for practicality to assist in such cases.

7.3 Response Plan

Reporting:

When suspicion arises that fraud, bribery or corruption has/is taking place, all employers/workers have the responsibility to report this matter. It is imperative therefore that all employees and workers feel confident to report any concerns without a risk to themselves. To support this policy, staff should be aware of the WP4A All Wales Procedure for NHS Staff to Raise Concerns (Whistleblowing Policy) and Speak Out Safely..

Details of how to report can be found in Appendix B.

The BCUHB Counter Fraud Team may receive reports from a number of sources which may include but is not limited to:

- Direct reports from staff/workers, patients or members of the public or stakeholders
- Direct anonymous reports via telephone, email or letter
- Reports via the NHS CFA reporting line or online reporting tool
- Reports made directly to the NHS Counter Fraud Service Wales
- Self-generated during preventative work

All reports will be taken seriously and dealt with appropriately. The Local Counter Fraud Team will triage each report and a decision will be made by the Head of Local Counter Fraud Service for BCUHB (acting as lead LCFS) on how the investigation will proceed.

Investigations:

All investigations conducted by the Local Counter Fraud Team will be done so in line with the following:

- Welsh Government directions to Counter Fraud in the NHS in Wales (2005)
- Data Protection Act 2018 (DPA)
- The Police and Criminal Evidence Act 1984 (PACE)
- The Criminal Procedure and Investigations Act 1996 (CPIA)
- The Public Interest Disclosure Act 1998. (PIDA)
- The NHS CFA Fraud and Corruption Manual
- Attorney General's Revised Guidelines for Disclosure
- Applying appropriate sanctions consistently (Policy statement).

There is a likelihood that the vast majority of cases where employees or workers are under investigation for fraud, bribery or corruption will have a disciplinary investigation which will run parallel. For this reason, it is important to ensure effective joint working between the Local Counter Fraud Specialist (LCFS), People and Organisational Development (POD) representative and the Disciplinary Investigation Officer (DIO).

The criminal and disciplinary investigations must be conducted separately and by different people. Criminal investigations must be conducted in accordance with PACE, the CPIA, and other relevant criminal legislation; disciplinary investigations must be carried out in accordance with the All-Wales Disciplinary Policy or Upholding Professional Standards in Wales, which follows the ACAS Code of Practice on Disciplinary and Grievance Procedures and relevant employment law.

The criminal investigation may be given precedence over the disciplinary investigation, if there is a risk of serious prejudice to the former from running the two processes concurrently. However, there may be a compelling public interest in suspending or removing an individual from their post before the conclusion of the criminal case; in this situation, a case conference should be held to discuss

the circumstances and relevant disclosure issues. Information may be shared between the LCFS, DIO and POD representative where and when it is lawful and appropriate.

In order to ensure that any criminal investigation is not prejudiced, the LCFS, POD representative and DIO will ensure:

- DIO and POD representative are responsible for informing the LCFS of any possible weaknesses in the case.
- Any interview under caution by the LCFS should take place before any fact-finding / disciplinary interview with the suspect, unless patient or public safety issues arise which necessitate a prompt fact finding interview (in which case the DIO, LCFS and POD representative can agree for the fact-finding interview to take place first if appropriate)
- The DIO, LCFS and POD representative should meet at regular intervals with the for updates on investigations whenever parallel sanctions are being considered to ensure a flow of information and avoid potential duplication. An accurate record should be recorded regarding the precise nature of the information that is being shared and the reasons why it is being shared.
- Where necessary and lawful to do so, the LCFS leading the investigation will provide sufficient evidence to the DIO and POD representative in order that a disciplinary investigation can be taken forward as appropriate. (E.g., a witness statement of LCFS investigation findings).

A parallel investigations flowchart can be found in Appendix C.

If a staff member under investigation by the BCUHB Counter Fraud Team for fraud, corruption, or bribery tenders their resignation during the course of the investigation, the inquiry should proceed to its conclusion. Should a decision be made, for any reason, to discontinue the investigation, the matter must be reported to the Audit Committee.

Sanctions:

When an objective investigation uncovers evidence of fraud, bribery, or corruption, the next step is to impose appropriate sanctions. The potential sanctions include:

- Criminal Prosecution: The Local Counter Fraud Specialist (LCFS) collaborates with the NHS Counter Fraud Service Wales, the police, and/or the Crown Prosecution Service to bring cases to court. Possible outcomes include criminal convictions, fines, or imprisonment.
- Civil Action: Civil proceedings may be initiated to recover fraudulently obtained money or assets, including associated interest and costs. Actions such as freezing assets or recovering losses may also be taken.
- Disciplinary Action: BCUHB can initiate disciplinary measures if an employee is implicated in fraudulent or illegal activities in line with Upholding Professional Standards in Wales or the All Wales Disciplinary Policy (WP9).

- Regulatory Action: If applicable, employees may be reported to their professional bodies following successful investigations or prosecutions.

Multiple sanctions may be pursued simultaneously for the same incident.
Each case is evaluated individually, considering its unique facts and merits. A consistent and thorough approach is applied to ensure:

- Effective investigations are conducted, including the collection and assessment of all relevant evidence related to fraud, bribery, corruption, misconduct, or unfitness to practice.
- The most appropriate sanction or combination of sanctions is determined and pursued.
- The appropriate senior manager, in collaboration with the People and Organisational Development Department, will oversee necessary disciplinary actions. If the individual remains employed by the Health Board, arrangements may be made to recover losses through payroll. All actions must comply with current legislation.

Redress:

In cases investigated by the Local Counter Fraud Team or NHS Counter Fraud Service Wales, where losses are identified, financial recovery will always be considered. Recovery efforts aim to return resources lost to fraud, bribery, or corruption to the NHS for their intended use—delivering high-quality patient care and services.

Redress options include:

- Confiscation or compensation orders
- Civil repayment agreements
- Local settlements between the organisation and the offender.
- Recovery from ongoing salary payments or pensions.
- In more significant cases, the NHS Counter Fraud Service Wales may seek restraining or confiscation orders under the Proceeds of Crime Act 2002 (POCA) to recover financial benefits.

Recovery efforts will begin promptly once a loss is identified. Collaboration between departments may be necessary to select the most appropriate recovery option. In some cases, with guidance from the LCFS and approval from the Executive Director of Finance and NHS Counter Fraud Service Wales, it may be decided that no further recovery action will be taken.
Further information on redress can be found in Appendix D.

Executive Director of Finance, in consultation with the LCFS and NHS Counter Fraud Service Wales, will determine whether a case should be referred to the police. This decision involves coordination with line managers as needed. Police referrals do not preclude action under All Wales Disciplinary Policy. Wherever possible, the BCUHB Counter Fraud Team or NHS Counter Fraud Service Wales will retain the investigation.

7.4 Risk Assessment and Identification

To ensure that risks are appropriately identified, managed and addressed, risk assessments related to fraud, bribery and corruption will be carried out. Where risks are identified, they will be investigated by the Local Counter Fraud Team and mitigating measures recommended wherever possible.
The management of risk will be conducted in line with the BCUHB Risk Management Framework. The lead LCFS/ Head of Local Counter Fraud Service will provide assurance around risk related to fraud, bribery and corruption to the Executive Board and Audit Committee and identify mitigation plans via the Counter Fraud Annual Workplan. Any risks identified will be referred to the risk register for the relevant directorate.

8. EQUALITY INCLUDING WELSH LANGUAGE

An Equality Impact Assessment has been undertaken in accordance with BCUHB Policy on Policies and WP7 - Procedure for Equality Impact Assessment (EqIA). BCUHB will not discriminate on grounds of age, disability, gender or gender reassignment, pregnancy or maternity, race, religion, belief and non-belief, sex, sexual orientation or marital status.

Appropriate and reasonable adjustments will be made where possible in relation to the investigation of fraud, which may include Interviews Under Caution (IUC); in accordance with the Police and Criminal Evidence Act (PACE) – 1984 Codes of Practice. An example of this would be to ensure that an Appropriate Adult is present, during an IUC to support the person being interviewed.

This policy will be submitted for translation once approved and available in both Welsh and English.

9. WELL-BEING OF FUTURE GENERATIONS

The Health Board's well-being objectives are to improve physical, emotional and mental health and wellbeing for all; to target resources to those with the greatest needs and reduce inequalities; to support children to have the best start in life; to work in partnership to support people- individuals, families, carers, communities- to achieve their own wellbeing; to improve the safety and quality of all services; to respect people and their dignity; to listen to people and learn from their experiences.

10. ENVIRONMENTAL IMPACT

An environmental impact assessment is not applicable to this Policy.

11. RESOURCES

The main resource required is the ongoing funding of the BCUHB Counter Fraud Team.

12. TRAINING

An e-Learning module relating to the awareness, of fraud, bribery and corruption, is available to staff for completion. The training is mandatory and must be updated every three years to ensure a strong counter fraud culture within the Health Board.

For staff unable to undertake e-Learning, a workbook is available from the Local Counter Fraud Team, and the team will also continue to provide Fraud Awareness training to new staff as part of the Health Board's Orientation Programme and also to specific staff groups or as part of management training programmes wherever appropriate. The Local Counter Fraud Service team will also provide Fraud Awareness training to Primary Care contractors as requested.

13. IMPLEMENTATION

The policy will be available to all staff on BetsiNet. An awareness programme will be conducted by the Local Counter Fraud Team which work alongside the policy to support understanding and implementation.

14. AUDIT

The effectiveness of this policy will be reviewed via the Audit Committee who will receive regular progress reports from the Head of Local Counter Fraud Service on counter fraud activity which has been undertaken by the Health Board.
Where deficiencies are identified as a result of monitoring, the Health Board Audit Committee will ensure that the appropriate recommendations and action plans are developed and implemented.
This will be achieved via the Audit Committee Tracker Tool.

15. REVIEW

This policy will be reviewed every three years or earlier if changes arise that necessitate updates to its content.

16. REFERENCES

Attorney General's Revised Guidelines for Disclosure (Gov.uk Website)
Data Protection Act 2018 (Legislation.gov.uk website)

Directions to NHS Bodies on Counter Fraud Measures (Welsh Government)
Government Functional Standard 013 (Gov.uk Website)
NHS Counter Fraud Authority – Applying appropriate sanctions consistently – Policy statement (April 2013)
NHS CFA Fraud and Corruption Manual
The Economic Crime and Corporate Transparency Act 2023
The Bribery Act 2010
The Criminal Procedure and Investigations Act 1996 (CPIA),
The Criminal Procedure Investigation Act 1996
The Fraud Act 2006
The Police and Criminal Evidence Act 1984 (PACE),
The Police and Criminal Evidence Act 1984 Codes of Practice
The Public Interest Disclosure Act 1998. (PIDA)
Welsh Government directions to Counter Fraud in the NHS in Wales (2005),
Welsh Government document Countering Fraud in the NHS in Wales (September 2001)

17. APPENDICES

APPENDIX A- Definitions
APPENDIX B - Reporting Guidance
APPENDIX C - Parallel Investigations flow chart
APPENDIX D - Fraud Financial Redress Procedure

17.1 APPENDIX A – DEFINITIONS

Fraud:

The NHS CFA definition of NHS fraud is used for the purposes of this Policy:
'On a basic level, fraud is deception carried out for personal gain, usually for money. Fraud can also involve the abuse of a position of trust. By 'NHS fraud' we mean any fraud where the NHS is the victim.'

The Fraud Act 2006 consists of a number of offences of fraud. Any investigations into reports of fraud will consider whether any offences under the Fraud Act 2006 have been committed.
The most common Fraud offences encountered against the NHS are:

- Section 2 - Fraud by false representation
- Section 3 - Fraud by failing to disclose information
- Section 4 - Fraud by abuse of position
- Section 11 - Obtaining services dishonestly

Examples of these crimes may include but are not limited to:

- Submitting false or forged timesheets
- Working elsewhere in NHS contracted hours
- Falsifying travel and/or expense claims
- People working for other agencies whilst off sick from the NHS
- Patient falsification of prescription claim forms
- Outside agencies duplicating invoices for payment by the NHS
- Contractors claiming payment for merchandise they have not delivered
- The unauthorised selling of NHS property or assets

Warning Signs to consider which may indicate Fraud can include the following:

- Altered documents (correcting fluid, different pen or handwriting)
- Duplicate claim forms
- Claim form details not readily checkable
- Changes in normal patterns, of e.g. cash takings or travel claim details
- Erratic text or difficult to read narrative or with details missing
- Delay in completion or submission of claim forms
- Lack of vouchers or receipts in support of expense claims, etc.
- Staff seemingly living beyond their means
- Staff under constant financial or other stress
- Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a 'risk' area
- Complaints from public or staff
- Always working late
- Refusal of promotion
- Insistence on dealing with a particular individual

Economic Crime and Corporate Transparency Act 2023 - Failure to Prevent Fraud:

This offence will hold organisations to account for fraud committed by their employees, agents, subsidiaries or other "associated persons" who provide services for or on behalf of the organisation, where the fraud was committed with the intention of benefiting the organisation or their clients. It does not need to be demonstrated that the organisation's senior managers or directors ordered or knew about the fraud. The offence will not extend to individual liability for persons within the organisations who may have failed to prevent the fraudulent behaviour. However, this does not preclude the employee or agent who committed the base fraud, or anyone who encouraged or assisted them, being prosecuted for the base fraud in addition to the corporate being prosecuted for failing to prevent it.
The offence is set out in sections 199-206 and Schedule 13 of the Economic Crime and Corporate Transparency Act 2023. BCUHB does meet the scope for an organisation as defined within the Act and if found guilty, the organisation can receive an unlimited fine.
Where fraud is committed within the organisation, BCUHB will have a reasonable defence of reasonable fraud prevention procedures. If a case comes to court, the onus will be on the organisation to prove that it had reasonable procedures in place to prevent fraud at the time that the fraud was committed. In accordance with established case law, the standard of proof in this case is the balance of probabilities.
The fraud prevention framework put in place by relevant organisations should be informed by the following six principles:

- Top level commitment
- Risk assessment
- Proportionate risk-based prevention procedures
- Due diligence
- Communication (including training)
- Monitoring and review.

Bribery:

The Bribery Act 2010 consists of a number of offences relating to bribery. Any investigations into reports of bribery will consider whether any offences under the Bribery Act 2010 have been committed.
The most common offences related to bribery encountered against the NHS are:

- Section 1: Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.

- Section 2: Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly.

- Section 7: Failure of a commercial organisation to prevent bribery (the corporate offence).

Corruption:

Corruption has been defined as: the offering, giving, soliciting or acceptance of an inducement or reward, which may influence a person to act against the interests of the organisation (Source: Audit Commission).
The term Corruption usually covers acts under the Bribery Act 2010 but can also encompass other offences such as Money Laundering.

Warning signs which may suggest Bribery or Corruption can include the following:

- Abnormal cash payments
- Pressure exerted for payments to be made urgently or ahead of schedule
- Payments being made through a third-party country - for example, goods or services supplied to country 'A' but payment is being made, usually to a shell company in country 'B'
- An abnormally high commission percentage being paid to a particular agency. This may be split into two accounts for the same agent, often in different jurisdictions
- Private meetings with public contractors or companies hoping to tender for contracts
- Lavish gifts being received
- An individual who never takes time off even if ill, or holidays, or insists on dealing with specific contractors himself or herself
- Making unexpected or illogical decisions accepting projects or contracts
- The unusually smooth process of cases where an individual does not have the expected level of knowledge or expertise
- Abuse of the decision process or delegated powers in specific cases
- Agreeing contracts not favourable to the organisation either because of the terms or the time period
- Unexplained preference for certain contractors during tendering period
- Avoidance of independent checks on the tendering or contracting processes
- Raising barriers around specific roles or departments which are key in the tendering or contracting processes
- Bypassing normal tendering or contracting procedures
- Invoices being agreed in excess of the contract without reasonable cause
- Missing documents or records regarding meetings or decisions
- Company procedures or guidelines not being followed
- The payment of, or making funds available for high value expenses or school fees (or similar) on behalf of others

17.2 APPENDIX B – REPORTING GUIDE

Do you have concerns about a fraud taking place in the NHS?

DO

- **Note your concerns as soon as possible-** Record details such as the nature of your concerns, names, dates, times, locations, details of conversations and potential witnesses. Time, date and sign your notes.
- **Report your suspicions-** Please find contact details of your Local Counter Fraud Service team or for the NHS Fraud, Bribery and Corruption Reporting Line on the next page
- **Provide as much information as possible-** All reports are assessed for content and accuracy. It is important that you provide as much information as possible (date, time, location, witnesses, evidence etc.) as this will give the LCFS the best start in looking into the matter and may provide valuable intelligence to help improve overall understanding of NHS fraud.
- **Know that confidentiality will be respected-** There are a number of ways to report suspected fraud, bribery or corruption against the NHS including reporting anonymously, if you chose to report in this way. You may also report as a Whistle-blower. To consider if you are covered to report under the Public Interest Disclosure Act 1998 (PIDA) please read the WP4A All Wales Procedure for NHS Staff to Raise Concerns (Whistle-blowing).
- **Do act!**

DO NOT

- **Confront the suspect or convey concerns to anyone other than those authorised (please see next page; LCFS or staff from the NHS Fraud, Bribery and Corruption Reporting Line)-** Never attempt to confront or question a suspect yourself. This could either alert the fraudster or cause an innocent person being unjustly accused.
- **Do not discuss your suspicions or concerns with other people-** If you are unsure about what to do if you suspect a fraud, discuss your suspicions with your LCFS.
- **Do not start your own investigation or gather evidence yourself-** Never attempt to gather evidence yourself. Contact your LCFS as soon as possible or call the NHS Fraud, Bribery and Corruption Reporting Line if you suspect a fraud even if you are not sure about everything, or do not know all the fact.
- **Be afraid of raising your concerns-** The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
- **Do nothing!** Depending on the nature and severity of the allegation, any delay in reporting may lead to further financial or reputational loss.

If you suspect that fraud against the NHS has taken place, you must report it immediately to:

- Your nearest Local Counter Fraud Specialist (LCFS) or any member of the BCUHB counter fraud team
- Or by telephoning the national number or logging the allegation online, details on the right.

NHS Fraud, Bribery and Corruption Reporting Line: 0800 028 40 60

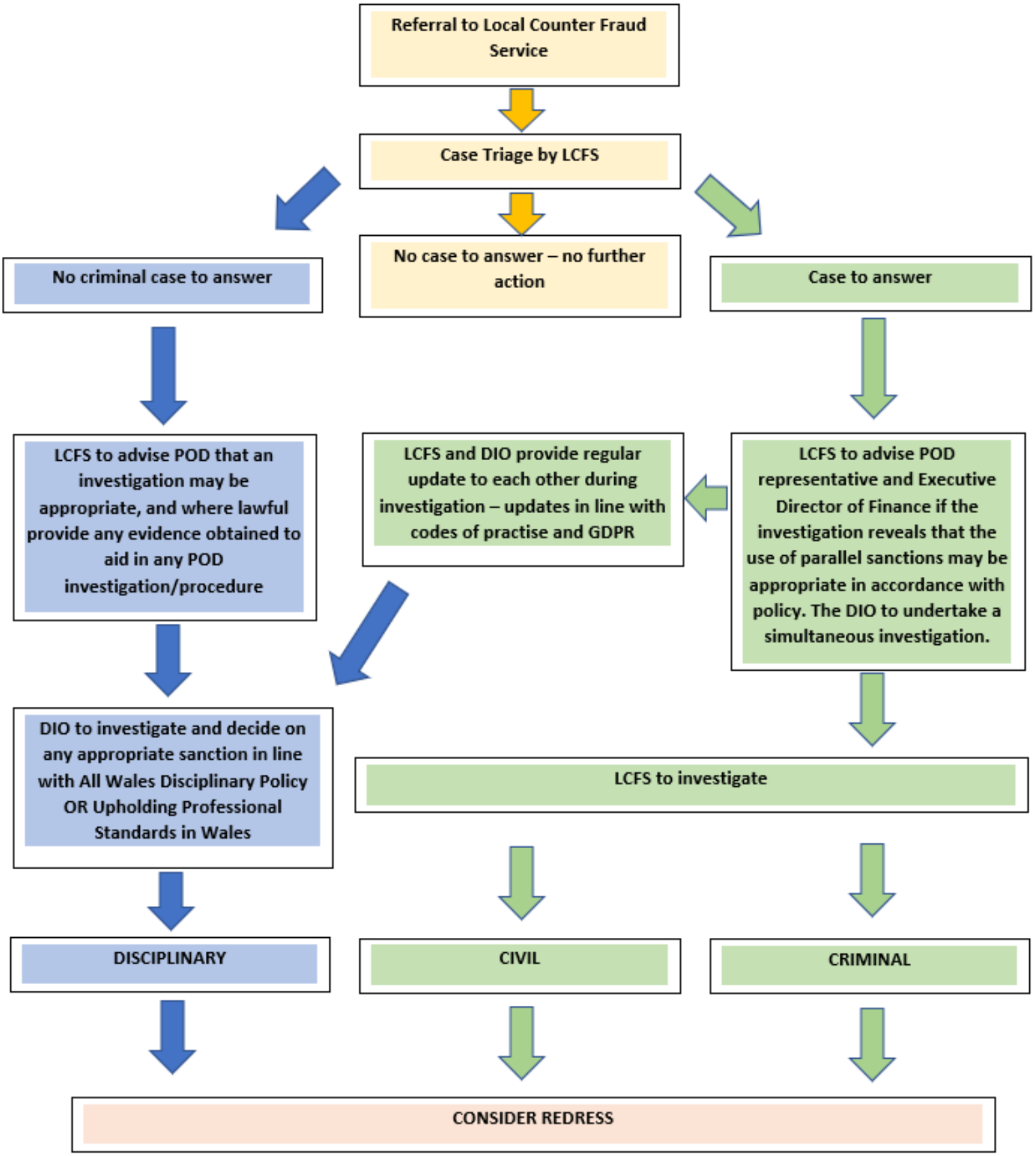
Calls will be treated in confidence and investigated by professionally trained staff.

OR

Online via the NHS Counter Fraud Authority Website.

Please help protect BCUHB from NHS fraud by telephoning your Counter Fraud Team in confidence. Visit the Counter Fraud page on BetsiNet for up-to-date contact information for the Counter Fraud Team or contact BCU.CounterFraudTeam@wales.nhs.uk

17.3 APPENDIX C – PARALLEL INVESTIGATIONS FLOWCHART



17.4 APPENDIX D - FRAUD FINANCIAL REDRESS PROCEDURE

The Local Counter Fraud Service team should:

- Take the appropriate action during the investigation with the relevant payroll or finance department officer to seek an accurate cost to quantify the value of any monies suspected to have been defrauded from the Health Board.
- Liaise with the Accounts Receivable team to raise an invoice for the full value of defrauded monies. To liaise with the Accounts Receivable team through-out the course of any voluntary or legal actions that may be required to recover defrauded monies.

In circumstances where Civil Redress is required to be undertaken for cases which involve fraud, the case will be transferred from the Accounts Receivable team to the Local Counter Fraud team, who will seek Civil Redress from the County Court / High Court, or where applicable from the NHS Pensions Agency.

The LCFS will consider a number of options to recover defrauded monies including the following:

- To seek voluntary recovery of the defrauded funds on a without prejudice basis to the criminal fraud investigation
- Prosecution - Seek an order of the court under the Proceeds of Crime Act and other relevant criminal legislation to achieve a full financial recovery
- Disciplinary - Seek from the disciplinary panel where a management case is proven and establishes the employee defrauded the NHS that the disciplinary panel decision includes the repayment of defrauded monies.
- Civil action - In the event of no voluntary repayment or that criminal and disciplinary sanctions fail to achieve a full financial recovery to refer the matter to the Health Board appointed Solicitor to consider a recovery through the civil courts, after out of court negotiation attempts by the Solicitor has been exhausted. The Solicitor will advise the investigating LCFS on recovery outcome who will inform the Accounts Receivable Team of any further action to be taken to recover the monies.

In the event that criminal, disciplinary and civil recovery action have been exhausted without a financial recovery being achieved and where further legal action would be uneconomical to pursue, approval to seek a ‘write off’ is as follows:

- Up to £5,000 – Approval required by Director of Finance: Operational Finance
- £5,000 to £50,000 – Approval required by the Executive Director of Finance
- Over £50,000 – Approval required by Welsh Government

In all cases the requirements of Welsh Government recording of losses must be complied with when writing off a fraud loss and reported as due process to the Health Board.

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable **N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

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

Asesiad / Assessment

The Committee considered the following matters in private session:

16 January 2025

- Local Counter Fraud Service Progress Report

Audit Committee – Non-Routine Committee Business Workplan

(1 April 2024 – 31 March 2025)

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

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
16.01.25	Audit Committee item AC25/04	Audit Committee	The Role of Internal Audit	The video developed has been shared at the AC Development Session in Feb 25 and an update to be provided to the April meeting in relation to the Comms plan and revised video.	Glesni Driver Dave Harries	Pam Wenger	30.04.25	On Track
16.01.25	Action AC25/10.1 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies Report on overdue policies (not WCDs)	An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April.	Glesni Driver	Pam Wenger	30.04.25	On Track
08.01.25	Action AC24/151.1 from Audit Committee	Pam Wenger	Review of Centre for Mental Health and Society (CfMHaS) / Report on FOI Request	A full evaluation report to be presented at Audit Committee – this was due to go to Jan / March but put forward for April meeting as the review will be commissioned externally.	Phil Meakin	Pam Wenger	30.04.25	On Track
25.02.25	Discussion with PW and PPJ re: March 25 agenda	PW & PPJ	Annual Report Compliance with the Corporate Governance Code	PPJ agreed with PW to put this forward from March 25 to	Philippa Peake-Jones	Pam Wenger	April / May 25	On Track
12.09.241	Action AC24/124.3 from Audit Committee	Audit Committee / Pam Wenger	June – Update on new process for policies	Establish a long term review of the process for reviewing policies and procedures.	Glesni Driver	Pam Wenger	24.06.25	On Track
1601.25	Audit Committee action AC25/05.4	Audit Committee	Final Internal Audit Report on Consultant Job Planning	Progress and oversight to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.	Sree Andole Nick Graham	Pam Wenger	Aug 25	On Track
24.08.24	Email from Andrea Hughes on 24.08.24	Andrea Hughes	Counter Fraud Policy – was due to Sept meeting but not ready, also not ready for Nov meeting, needs to go to consultation (see email from AH 24.10.24) Latest update from AH 21.11.24 policy won't be ready to go in Jan 25 so put forward for March 25.	• Counter Fraud Policy to go to Committee. • Draft Policy in development and being progressed by Head of Counter Fraud. Action AC24/166.1 to be addressed in the policy.	Danielle Timmins	Russell Caldicott	04.03.25	**CLOSED** Went to Comm in March 25
05.11.24	Action AC24/167.1	Audit Committee	Section 117 Mental Health Placements (Private agenda)	Present an update paper to the Committee.	Russell Caldicott	Russell Caldicott	04.03.25	**CLOSED** No further action needed
12.09.24	Action from Audit Committee 12.09.24	Audit Committee	Audit Wales Community Pharmacy Data Matching Pilot	Lois Lloyd to provide an update to the Committee	Lois Lloyd	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25

16.09.24	Action AC24.94.9 from Audit Committee	Audit Committee	Effective Governance – (IHC) Central - Final Internal Audit Report	Update on the impact of the actions being taken to reduce the number of outstanding complaint responses (see email sent to Di Platt 01.10.24) PW suggested adding to agenda under an item – Update on Internal Audit Actions (see email from PW 08.10.24)	Gareth Evans / Di Platt	Gareth Evans	16.01.25	**CLOSED** Went to Comm in Jan 25
24.10.24	Action AC24/124.2 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies	A summary as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.	Glesni Driver	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
29.10.24	Email from Pam re: Action AC24.43.6 from Audit Committee	Pam Wenger	Welsh Risk Pool	Level of exposure costs in terms of WRP payments	Matt Joyes	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
05.11.24	Action AC24.154.4 from Audit Committee	Audit Committee	Internal Audit Progress Report	Due to the lack of regular oversight of the Llandudno Hospital Orthopaedic Surgical Hub invite Chris Stockport to join the January 25 meeting (this is also being noted via PFIG)	Pam Wenger	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
02.09.24	Action from Audit Committee 18.07.24 Action AC24.95.7	Audit Committee	Session with Board Members to discuss the role and operations of Shared Services	This has been included on the Audit Committee Development Plan	Pam Wenger	Pam Wenger	05.11.24	**CLOSED** This is included on the AC Development Plan
02.09.24	Action from private Audit Committee 21.05.24	Audit Committee	Development session with Board Members on Counter Fraud	This has been included on the Audit Committee Development Plan	Pam Wenger	Pam Wenger	05.11.24	**CLOSED** This is included on the AC Development Plan